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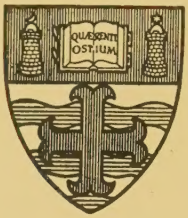

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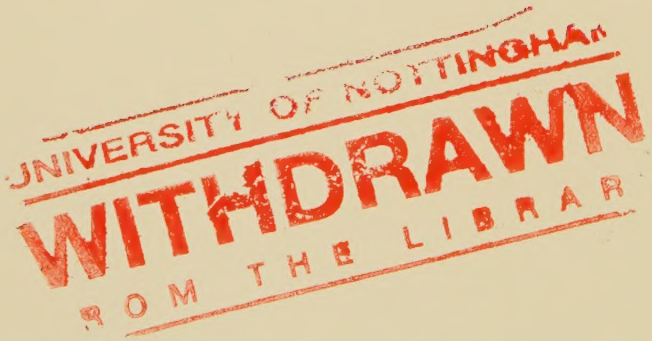

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REPORT

OF THE

ROYAL COMMISSION

ON

NATIONAL HEALTH INSURANCE

Presented to Parliament by
Command of His Majesty

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ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE.

(Appointed by Royal Warrant dated the 11th July, 1924.)

TERMS OF REFERENCE.

To inquire into the scheme of National Health Insurance established by the National Health Insurance Acts, 1911-22, and to report what, if any, alterations, extensions or developments should be made in regard to the scope of that scheme and the administrative, financial and medical arrangements set up under it.

MEMBERSHIP OF THE COMMISSION.

Lord LAWRENCE OF KINGSGATE, *Chairman.*
The Rt. Hon. Sir JOHN ANDERSON, G.C.B.
Sir HUMPHRY ROLLESTON, Bart, K.C.B., M.D., P.R.C.P.
Sir ALFRED WATSON, K.C.B., F.I.A., F.F.A.
Sir ARTHUR WORLEY, C.B.E.
Sir ANDREW DUNCAN.
Mr. A. D. BESANT, P.I.A.
Mr. FRED BRAMLEY.*
Mr. JAMES COOK.
Mr. JOHN EVANS.
Professor ALEXANDER GRAY.
Mr. WILLIAM JONES.
Mrs. F. N. HARRISON BELL.
Miss GERTRUDE TUCKWELL.

Mr. E. HACKFORTH (*Secretary*).
Mr. J. W. PECK, C.B. (*Assistant Secretary*).

---

* Resigned 11th March, 1925

WARRANT OF APPOINTMENT.

GEORGE R.I.

GEORGE THE FIFTH, by the Grace of God, of the United Kingdom of Great Britain and Ireland and of the British Dominions beyond the Seas King, Defender of the Faith, to

Our Right Trusty and Well-beloved CHARLES NAPIER, Baron Lawrence of Kingsgate;

Our Right Trusty and Well-beloved Counsellor Sir JOHN ANDERSON, Knight Grand Cross of Our Most Honourable Order of the Bath, one of the Under Secretaries of State to Our Principal Secretary of State for the Home Department;

Our Trusty and Well-beloved :—

Sir HUMPHRY DAVY ROLLESTON, Baronet, Knight Commander of Our Most Honourable Order of the Bath, Doctor of Medicine, President of the Royal College of Physicians of England;

Sir ALFRED WILLIAM WATSON, Knight Commander of Our Most Honourable Order of the Bath, Government Actuary;

Sir ARTHUR WORLEY, Knight, Commander of Our Most Excellent Order of the British Empire;

Sir ANDREW RAE DUNCAN, Knight;

ARTHUR DIGBY BESANT, Esquire, President of the Institute of Actuaries;

FRED BRAMLEY, Esquire;

JAMES COOK, Esquire;

JOHN EVANS, Esquire;

ALEXANDER GRAY, Esquire, Professor of Political Economy in Our University of Aberdeen;

WILLIAM JONES, Esquire;

FLORENCE NIGHTINGALE HARRISON BELL, Widow of the late JOSEPH NICHOLAS BELL, and

GERTRUDE MARY TUCKWELL, Spinster :

Greeting !

Whereas We have deemed it expedient that a Commission should forthwith issue to inquire into the scheme of National Health Insurance established by the National Health Insurance Acts, 1911-22, and to report what, if any, alterations, extensions or developments should be made in regard to the scope of that scheme and the administrative, financial and medical arrangements set up under it :

Now know ye, that We, reposing great trust and confidence in your knowledge and ability, have authorised and appointed, and do by these Presents authorise and appoint you, the said Charles Napier, Baron Lawrence of Kingsgate (Chairman), Sir John Anderson, Sir Humphry Davy Rolleston, Sir Alfred William Watson, Sir Arthur Worley, Sir Andrew Rae Duncan, Arthur Digby Besant, Fred Bramley, James Cook, John Evans, Alexander Gray, William Jones, Florence Nightingale Harrison Bell, and Gertrude Mary Tuckwell to be Our Commissioners for the purposes of the said inquiry :

And for the better effecting the purposes of this Our Commission, We do by these Presents give and grant unto you, or any three or more of you, full power to call before you such persons as you shall judge likely to afford you any information upon the subject of this Our Commission ; to call for information in writing and also to call for, have access to and examine all such books, documents, registers and records as may afford you the fullest information on the subject, and to inquire of and concerning the premises by all other lawful ways and means whatsoever :

And We do by these Presents authorise and empower you, or any of you, to visit such places as you may deem expedient for the more effectual carrying out of the purposes aforesaid :

And We do by these Presents will and ordain that this Our Commission shall continue in full force and virtue, and that you, Our said Commissioners, or any three or more of you, may from time to time proceed in the execution thereof, and of every matter and thing therein contained, although the same be not continued from time to time by adjournment :

And We do further ordain that you, or any three or more of you, have liberty to report your proceedings under this Our Commission from time to time if you shall judge it expedient so to do :

And Our further will and pleasure is that you do, with as little delay as possible, report to Us, under your hands and seals, or under the hands and seals of any three or more of you, your opinion upon the matter herein submitted for your consideration :

Given at Our Court at St. James's the eleventh day of July, one thousand nine hundred and twenty-four, in the fifteenth year of Our Reign.

By His Majesty's Command,

Arthur Henderson.

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NOTE.

References to statements of evidence submitted by witnesses to the Commission, and to questions answered by witnesses, are made in the following form:—

"App.," followed by a Roman numeral and a number, indicates the particular Appendix to the Minutes of Evidence and the paragraph referred to.

"Q." followed by a number, indicates the particular Question and Answer in the Minutes of Evidence.

ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE.

REPORT.

To the King's Most Excellent Majesty.

May it please Your Majesty,

We, the undersigned Commissioners appointed under Your Majesty's Royal Warrant of the 11th July, 1924,

> " to inquire into the scheme of National Health Insurance established by the National Health Insurance Acts, 1911-22, and to report what, if any, alterations, extensions or developments should be made in regard to the scope of that scheme and the administrative, financial and medical arrangements set up under it "

humbly beg leave to report as follows :—

CHAPTER I.

INTRODUCTION.

Procedure of the Commission.

1. We held our first meeting on the 17th July, 1924, and at that meeting considered generally our Terms of Reference and also discussed certain preliminary questions of procedure, including amongst others that of the expedience of admitting the Press and the public to those meetings at which witnesses were to tender evidence and submit to examination. We subsequently decided that, on a balance of considerations, our work could probably be discharged with greater efficiency in the absence of those restraints which the presence of the public might impose on certain witnesses. In view of the general interest felt in the questions submitted to us and of the large sections of the population who might be directly affected by any conclusions at which we might arrive, we felt, however, that it was of the utmost importance that the widest possible publicity should be given to our proceedings, not merely from the point of view of informing those immediately concerned, but also with the object of stimulating further evidence whether by way of comment upon or of criticism of, the evidence which might be tendered to us. We accordingly decided that a short summary of the proceedings

at each meeting should be issued to the Press immediately after the meeting, and further we arranged that verbatim reports of the evidence given before us at each meeting should be published and placed on sale within two weeks of the date of the meeting.

2. We are glad to be able to record that the procedure so adopted fulfilled admirably the purposes for which it was designed and that the weekly report of our proceedings enjoyed throughout a considerable and a steady sale, which reached a weekly average of over 600 copies. At the same time notices were inserted in the public Press inviting any bodies or persons who desired to make representations on matters falling within the scope of our inquiry to apply to submit evidence before us. All who were so desirous of presenting evidence were required, in the first place, to submit written statements summarising the evidence which they desired to give. We received in all 143 such statements. Of these 130 are printed in full in the Appendix to our Minutes of Evidence, where there will also be found summaries of the remaining 13. Each of these statements was first considered by us with a view to our deciding whether it was necessary or desirable that we should hear oral evidence in amplification of the statement submitted. Of the 143 statements 107 were made the subject of oral examination of witnesses, who numbered 195, and to whom we addressed 24,815 questions. Lists of the witnesses examined and the bodies which they represented are prefixed to the volumes of the Minutes of Evidence in which their examination appears, and are also given in Appendix B to our Report. We held 45 sittings for the purposes of oral examination, including two sittings held in Edinburgh for the convenience of Scottish witnesses, and on all but three of these occasions we took evidence both in the morning and the afternoon. We also held several meetings for the discussion of the evidence we had received and for the formulation of our recommendations.

3. During the course of our proceedings we were deprived of the assistance of one of our members, Mr. Fred Bramley, who, after being able to attend only a few of our meetings, was compelled on account of ill-health to resign from the Commission on the 11th March, 1925. It was with great regret that we learned of his death some seven months later.

Types of Evidence.

4. The witnesses from whom oral evidence was heard, in addition to representatives of the five Government Departments concerned, namely, the Ministry of Health, the Scottish Board of Health, the Ministry of Labour, the National Insurance Audit Department and the Government Actuary's Department, included representatives of the Approved Societies and Insurance

Committees engaged in the administration of the Scheme of National Health Insurance. We also heard evidence from representatives of the medical profession, from chemists, dentists, nurses, ophthalmologists, opticians, hospital authorities, Medical Officers of Health, Poor Law Guardians, and others, including several persons who did not speak in a representative capacity but as individual observers and critics of the Scheme. The greater part of the evidence, perhaps inevitably, came from persons or bodies taking some part in the operation of the Scheme of National Health Insurance, or desiring to be associated in that work in the event of its extension. We could have wished that more evidence had been forthcoming from the insured persons themselves or from their employers but, while we took such steps as we thought practicable to obtain evidence from these sources, we recognised the difficulty in securing evidence which could be considered to be truly representative of the general body of insured workers and the employers of labour. We received, however, the considered views of the National Confederation of Employers' Organisations (Appendix CVII) which were directed mainly to the burden imposed on industry in a time of great financial and economic difficulty by the contributions levied for the various schemes of Social Insurance. The point of view of the average insured person, who is in such matters elusive and inarticulate (if indeed he can be said to exist at all), was to some extent indicated by the evidence submitted from the Inquiry Room of the Ministry of Health (Appendix XLI) and by the evidence of certain witnesses, as for example Dr. Harry Roberts, who are intimately in contact with insured persons and who speak from a wide experience.

Schemes of Sickness and Invalidity Insurance in other Countries.

5. The Ministry of Health have submitted to us a full and interesting account of the State schemes for insurance against sickness and invalidity in 14 European countries (App. CVIII). This illustrates the remarkable extent to which such schemes have been adopted and developed in countries of widely varying economic position and social habits, and undoubtedly provides much matter of interest to the student of these social problems. It may be remarked that any scheme of the kind under discussion must necessarily have regard to the peculiar social and industrial conditions of the country in which it operates, and that therefore in its machinery, if not in its principles, it must be developed on its own lines.

The Actuarial Committee.

6. At the outset of our investigation it became evident to us that for the proper consideration of the financial side of the

subject with which we were appointed to deal, expert actuarial advice would be essential. We, therefore, approached the Minister of Health, recommending that he should set up a Departmental Actuarial Committee to assist us in dealing with such actuarial questions as would necessarily arise in the course of our investigation. This recommendation was accepted by the Minister, who, on the 19th November, 1924, appointed a Committee under the chairmanship of Sir Alfred Watson, the Government Actuary and a member of the Commission, with the following terms of reference :—

> " To advise the Royal Commission on National Health Insurance actuarially as to whether the present basic contribution under the National Health Insurance Acts is in fact required for the existing benefits (including the cost of Societies' and Insurance Committees' administration), or whether such a rearrangement of the financial basis of the Scheme would be justified as would reduce the amount allocated to the present benefits and leave a margin for other purposes ; and thereafter to continue in being to furnish such further actuarial advice as may be required by the Royal Commission on any matters arising in the course of their inquiry."

In addition to the Chairman the Committee was composed of Mr. A. D. Besant, President of the Institute of Actuaries, who is also a member of the Commission, Mr. A. Henry, the Deputy Government Actuary, and Messrs. R. G. Maudling and L. E. Clinton, Fellows of the Institute of Actuaries. The Committee presented to us three reports dated 13th October, 1925, 7th December, 1925, and 18th December, 1925, and these appear as Appendix A to our Report. We desire to acknowledge our indebtedness to the Committee for the valuable assistance which we have derived from their labours.

CHAPTER II.

THE SCHEME OF NATIONAL HEALTH INSURANCE.

History of the Scheme.

7. The Scheme of National Health Insurance in this country had its origin in the National Insurance Act of 1911, which was described in its Preamble as " an Act to provide for insurance against loss of health and the prevention and cure of sickness and for purposes incidental thereto." The Scheme came into operation on the 15th July, 1912, and had therefore been in operation for a period of 12 years at the time when we were appointed to make the first general and comprehensive investigation into its working.

8. During these 12 years the Scheme of Health Insurance has not been without its history—a history which is reflected in a fairly continuous series of amending Acts of varying degrees of importance stretching from 1913 to the Consolidating Act of 1924. These various legislative alterations may, broadly, be ascribed to two main causes. In the first place, the original Act, viewed merely as a piece of legislation, was planned on a generous scale, and was drafted on the assumption that special provision should be made for any class of the population which appeared to call for special treatment. For example, aliens and those workers whose conditions of employment guaranteed them payment of wages during a certain period of incapacity, were the subject of special legislative provision. Moreover, other sections of the Act aimed at dispensing justice as between individuals in matters where abstract justice could only be achieved by machinery which in the circumstances could not fail to be burdensome in administration. As examples of such it may be permissible to cite the original provision made for the calculation and the imposition of penalties for arrears, the provision with regard to late entrants to insurance, and the arrangements for transfer between compulsory and voluntary insurance. In the light of subsequent events the original Act might be criticised for its implicit underlying assumption that the individuals composing the population are " classifiable " in a sense in which, in fact, they are not. Consequently, no doubt, certain sections of the Act, irreproachable in themselves and based on the assumption that the population as a whole was stabilised, were found to be out of touch with the realities of the situation. In short, the original Act was in many respects complex with a complexity which in practice yielded no adequate compensating advantage, and the realisation of this fact led to one series of amendments, those aiming at simplification of enactment and of administration.

9. The second main cause leading to amendment of the Act is to be found in the War and its economic consequences. It is a striking tribute to the general soundness of the lines on which the original Act was constructed that its administration was able to bear the severe strain imposed by war conditions at so early a date in its history. In relation to National Health Insurance the War did not merely occasion great difficulties in carrying on a scheme largely dependent on voluntary work and still in its early stages, but it raised problems calling for legislation to secure a measure of adaptation to the new conditions brought about, among many changes, by the absorption of so large a proportion of the population in the Forces, the grant of war pensions to disabled men and the general rise in the level of wages.

The Amending Acts.

10. Without entering into any detail, it may be convenient to refer briefly to some of the more important amending Acts passed during the period under review. The earliest Act was that of 1913, the immediate object of which was to make provision by Exchequer grant for the additional cost of medical benefit. At the same time, the opportunity was taken to give effect to a certain number of minor amendments the need for which had been disclosed in the early period of the operation of the Act. In 1915 and 1917 two Acts were passed in order to effect an adjustment in the rate of benefit payable to discharged soldiers in receipt of total disability pensions. Much more important was the Act of 1918, which followed the Report of the Departmental Committee on Approved Society Finance and Administration. The object of this Act was primarily to give effect to certain financial adjustments in the Scheme designed to strengthen the position of the weaker Societies; but it also introduced a large measure of simplification in regard to a considerable number of administrative details. Of later measures two, passed in 1919 and 1920, were occasioned by changing economic conditions, the first raising the limit for insurance of non-manual workers from a rate of remuneration of £160 to £250 a year, and the second increasing the rates of contributions and of benefits. Apart from these, it is only necessary to refer generally to the Acts dealing with the cost of medical benefit and to mention as of special interest the Act which made provision for prolongation of insurance in certain cases in order to meet the hardship occasioned by the general prevalence of unemployment. It was inevitable that this considerable volume of uncoordinated legislation should add not a little to the difficulties of administration and it was of material advantage to all concerned when in 1924 the whole of the existing legislation relating to National Health Insurance (with the exception of certain temporary provisions) was consolidated

in the National Health Insurance Act, 1924, which came into operation on the 1st January, 1925.

Previous Inquiries into the Scheme.

11. We have spoken of the present inquiry as being the first general and comprehensive investigation into the working of the Scheme. There have, inevitably in a scheme of this magnitude, been several inquiries into certain aspects of its operation. Of these, two call for mention by reason of their wider scope and their more general interest. The first was the Committee which sat under the Chairmanship of Sir Claud Schuster in 1913-14 to inquire into allegations that excessive sickness claims were being made on the funds of Approved Societies. The report of this Committee presents an interesting account of the working of Societies at the outset of the Scheme and of the difficulties of administration which confronted them. Issued at the beginning of the War, and in consequence overshadowed by greater events, the report had less practical effect than might have ensued had it appeared in happier circumstances. The other inquiry of considerable importance was that which in 1916 reported on questions of Approved Society finance and administration. This Committee, of which Sir Gerald Ryan was Chairman, devoted a large measure of its attention to questions of simplification, an end desirable in itself yet appearing particularly desirable under the stress of war. The labours of this Committee were reflected, as has been noted, in the very considerable amending Act of 1918.

Outline of the Scheme.

12. A full description of the present legislative provisions governing National Health Insurance, as contained in the Acts and the Statutory Regulations and Orders made thereunder, together with an account of the method of administration of the Scheme in England, was supplied to us by the Ministry of Health and is contained in Part I of the Appendix to our Minutes of Evidence. The same volume also contains statements supplied by the Scottish Board of Health and the Welsh Board of Health respectively, showing the variations in those countries from the position as set out in the English statement. As these complete statements with regard to the law and the method of administration of the Scheme are included in the official record of our proceedings, we do not think it necessary here to give more than the broadest descriptive outline of the system.

13. The Scheme of National Health Insurance in this country is on a compulsory and contributory basis. The persons who are required to be insured are, subject to certain exceptions, all those between the ages of 16 and 70 who are employed under

a contract of service in manual labour, or in non-manual employment at a rate of remuneration not exceeding £250 a year. The total number of persons insured exceeds 15,000,000. Certain employments, although falling within the general definition given above, are excepted from compulsory insurance, the chief of these being employment under the Crown or a Local Authority where the conditions of employment include provision against sickness not less favourable than that secured under the Act. Provision is also made under which employed persons who are in receipt of a pension or private income of £26 a year or upwards, or who are ordinarily and mainly dependent on some other person, or some non-insurable occupation, may secure exemption, in which case they themselves, but not their employers, are exempted from the liability to pay contributions. The total number of exempt persons has never been considerable, and is at the present time only about 36,000. In addition to the persons (known as employed contributors) who are required to be insured, the Scheme provides for the inclusion as voluntary contributors of persons who, after having been employed and insured for at least two years, elect, on ceasing to be insurably employed, to continue in insurance, paying the whole weekly contribution themselves. The number of voluntary contributors is at present only about 32,000. It may be observed that the present provisions relating to voluntary contributors represent a great restriction on the arrangements contemplated in the original Act. At the outset the Scheme provided for the inclusion as voluntary contributors of those persons who, by reason of the fact that they worked on their own account, did not come under the compulsory provisions of the Act. The response made, however, showed that there was practically no demand for insurance on a voluntary basis, and accordingly in 1918 future admission to the class of voluntary contributors was restricted to those who had for a definite period been insured as employed contributors.

14. The cost of the Scheme is shared between the insured persons, their employers and the National Exchequer. The revenue is derived, in the first instance, from weekly contributions paid partly by the workers and partly by their employers by means of health insurance stamps affixed to contribution cards, the rates of contribution in 1925 being 10*d.* a week in the case of men, of which 5*d.* was payable by the employer and 5*d.* by the worker; and 9*d.* in the case of women, of which 5*d.* was payable by the employer and 4*d.* by the worker. As from the 4th January, 1926, these rates have been reduced to 9*d.* a week in the case of men (employer 4½*d.*, worker 4½*d.*) and 8½*d.* a week in the case of women (employer 4½*d.*, worker 4*d.*) consequent upon the modifications in the benefits of the Scheme which follow from the provision of pensions at 65 under the recent Widows', Orphans', and Old Age Contributory Pensions Act. The contri-

bution from the National Exchequer towards the cost of the Scheme, apart from the cost of the Central Departments, takes the form of the payment of two-ninths of the total cost of the benefits and of their administration, payable on disbursement, that is to say, a payment by a Society attracts the State contribution of two-ninths.

The total income received from contributions in the year 1924 amounted to £27,377,000, and a sum of about £5,000,000 was derived from interest on accumulated funds. The expenditure on benefits was £26,118,000, and the cost of administration of these benefits by Approved Societies and Insurance Committees was £3,804,000. The total expenditure from the Exchequer towards the cost of the Scheme, inclusive of the cost of the central Government Departments concerned in the administration, was £7,045,000.

15. The benefits provided under the Scheme are :—

(1) Medical benefit, i.e., medical treatment and attendance, including the provision of proper and sufficient medicines and of the prescribed medical and surgical appliances.

(2) Sickness benefit, i.e., periodical payments during incapacity for work through illness. The ordinary rates of sickness benefit are 15*s*. a week for men, and 12*s*. a week for women, commencing on the fourth day of incapacity and continuing for a maximum period of 26 weeks.

(3) Disablement benefit, i.e., a continuance of periodical payments during illness at the reduced rate of 7*s*. 6*d*. a week for both men and women after the title to sickness benefit has been exhausted.

(4) Maternity benefit, i.e., payment of the sum of £2 on the confinement of an insured woman or the wife of an insured man. (A total sum of £4 is payable in the case of a married woman who is or has recently been herself an employed contributor ; these cases represent 25 per cent. of the whole number of payments to married women.)

(5) Additional benefits, which may be provided by an Approved Society having a disposable surplus on valuation, and may take the form either of an increase of the normal cash benefits, or payment towards the cost of various forms of treatment, such as dental, ophthalmic, hospital or convalescent home treatment.

16. The Act makes provision for variation from the normal contributions or benefits in the case of certain special classes of insured persons, such as women who cease employment on marriage, men serving in the armed forces of the Crown, seamen of the Mercantile Marine, and others. There are also special

provisions on a non-insurance basis for that class of persons known as deposit contributors, who cannot, or do not attempt to, obtain admission to an Approved Society. The existence of this class, which in 1911 was not intended to be given permanent existence, raises a number of difficult problems, which are discussed in Chapter XII of our Report.

17. A general supervision over the administration of the Scheme on behalf of the Central Government is undertaken in England and Wales by the Ministry of Health and in Scotland by the Scottish Board of Health. These Departments have an outside staff of inspectors distributed over the country, whose primary duty is to secure compliance with the provisions of the Act relating to the payment of contributions. The prompt payment of the contribution in respect of the 15 million insured persons week by week is a feature of the Scheme essential on financial grounds and remarkable as a piece of administrative machinery. The administration of medical benefit and of certain minor matters relating to deposit contributors and other classes is entrusted to specially appointed bodies, created under the Act of 1911, known as Insurance Committees. Such a Committee exists in each county and county borough in England and Wales and in each of the counties and larger burghs in Scotland. There are in England and Wales 145 such Committees, and in Scotland, 54. The cash benefits and additional benefits are administered by Approved Societies, which are self-governing bodies of insured persons who elect to group themselves together for the purposes of the Act. There are at the present time about 1,000 Approved Societies engaged in the administration of the Act, including 31 Societies with Branches. The Branches, which number about 7,000, are independent financial units for the purpose of National Health Insurance; they possess also a considerable measure of administrative independence, but are integral parts of the parent organisations to which respectively they belong and are subject to the general authority thereof. Approved Societies are not as a rule organised on any territorial basis, though in the nature of the case the membership of many of them is preponderantly localised. They vary in membership from less than 50 to more than 2,000,000 insured persons. Some are restricted to persons engaged in particular occupations or belonging to particular religious denominations or having some other common bond of interest; while others are open to all insured persons without qualification. For certain purposes Approved Societies may also be conveniently viewed in relation to other work carried on by them or their promoters, and from this point of view they may be classified into Societies formed in the Friendly Society movement, those instituted by the great Industrial Insurance Companies, those organised in connection with Trade Unions, and

various other types of less importance numerically. Of these latter, Societies promoted by employers may be cited as a group which presents features distinguishing them in certain respects from other Societies. This division of the insured population into self-contained units is a fundamental feature of the present Scheme and it leads to remarkable consequences, both of a financial and of a social nature. The surpluses built up vary over a very wide range owing to the diversity of sickness and maternity experience in the different Societies, and the scales of additional benefits which can be provided are correspondingly varied. To this feature, which we regard as one of the central problems before us, we shall devote considerable attention in Chapter IX of our Report.

18. The accounts of Approved Societies and Insurance Committees are audited by the National Insurance Audit Department, which is a Department under the Treasury. A full statement as to the methods and results of these audits will be found in Appendix CI.

CHAPTER III.

THE GENERAL ATTITUDE TO THE HEALTH INSURANCE SCHEME.

The Fundamental Character of the Scheme.

19. It will be remembered that, whereas the Scheme of National Health Insurance received a cordial reception on its first presentation to Parliament, a considerable volume of opposition was developed during the passage of the Bill and in the ensuing period before the Act came into full operation. The opposition, coming from various quarters, was directed against different aspects of the measure and based on considerations which had little in common. It is unnecessary here to consider the nature of the criticisms and the opposition of the Medical Profession, the threatened passive resistance of certain sections of the population or any of the other phases of antagonism to the Act. It is only fair to record that some of the original opposition was not professedly opposition to the general principles of the Act, but was rather directed to the administrative arrangements and the financial provisions made under it. Yet even so, it might have been expected that the appointment of the present Commission with its wide terms of reference and the publicity given to them, would have resulted in adverse representations being made to us on lines familiar to those who remember the exacerbation of spirit of 1911 and 1912.

20. In fact, however, we have received very little evidence directed against the Scheme as a whole, nor have we any reason to think that there now exists any considerable body of opinion adverse to the principle of National Health Insurance. The British Medical Association in their statement of evidence (Appendix XLVII) expressed a doubt as to whether under a limited expenditure out of public funds the best results in the way of improvement of the national health might be expected to be derived by the application of the money on the lines of the Scheme of National Health Insurance. They suggested that there were a number of other directions in which an equivalent expenditure would probably produce greater benefit to the public health, and they gave as instances of this, proper housing, town planning with due provision of open spaces and recreation facilities, smoke abatement, a pure milk supply, aid to medical research, and the like. Dr. B. G. M. Baskett submitted a statement (Appendix CXIX) in which he expressed the view that the efforts of the State to promote improvement in the general health of the community were not most profitably directed through a Health Insurance Scheme, and that in short " the only secure method

of improving the national health is to raise the national standard of living—that is to raise real wages."

21. It is perhaps permissible to concede the importance of the main consideration emphasised by Dr. Baskett without in fact admitting that it is relevant to the propriety of a system of insurance. It may cogently be argued that the general standard of living, of comfort and of well-being has a supreme influence on the health of the country; it does not follow that at any given stage a system of health insurance may not be expedient as machinery to obtain the best results in given conditions, nor can it be logically suggested that the existence of a health insurance scheme implies the denial of other methods of improving the health of the community. The observations of the British Medical Association are substantially, as it appears to us, directed to the same point. There are, it is true, many things, such as housing, town planning, smoke abatement and pure milk, which equally with medical attendance are essential to the public health. They are adjuncts to each other (Q. 14,796-9). Given "an immense sum of money," (Q. 14,805), it might conceivably be spent more advantageously, it is suggested, on certain of these essential adjuncts of medical service. We thus read the British Medical Association's evidence as a useful reminder that medical attendance is not in itself all that is necessary, not as implying any fundamental criticism of medical benefit as now provided. Mention may also be made of Lt.-Colonel Bickerton-Edwards (Appendix LII) and Dr. Milson Russen Rhodes (Appendix CXXI), who criticised the scheme on fundamental matters on its health side, the latter indeed going so far as to recommend a State medical service of salaried practitioners. Other witnesses, in their criticism, suggested such extensions of the Scheme in one direction or other, as would have rendered the insurance basis no longer appropriate.

22. In contrast to the paucity of evidence directed against the general principles of the present Scheme, we received from many different quarters a large volume of evidence in its favour, testifying to the advantages in health and social security which had been derived under it. For instance, the British Medical Association said that "the evidence as to the incidence of sickness benefit does point to the fact that the Scheme itself has almost certainly reduced national sickness, and we are quite sure that if the immense gain to national health includes immense gain to the comfort of the individual in knowing that he can have medical attention whenever he needs it, the gain is most marked; . . . ." (Q. 14,613). Witnesses appearing on behalf of the Ministry of Health stated that "medically the Insurance Acts have educated the population." (*Brock* Q. 23,852.) "It

(the Act) has made itself felt throughout the whole of the industrial population." (*Brock* Q. 23,856.)

23. While the general principles of the Scheme are thus accepted, and indeed approved by most of the witnesses who appeared before us, we have found a considerable volume of criticism directed against certain aspects of the operation of the Act, as disclosed in the results of thirteen years' experience. It may be permissible in this Chapter to summarise and review with the utmost brevity the points to which such criticism has in the main been directed, reserving for later discussion a more detailed consideration of the critical arguments advanced.

The Scope of the Scheme and the Sources of Revenue.

24. In the first place, it may be observed that apart from the suggestions as to the lowering of the age at which insurance should begin, to which reference is made in Section A of Chapter XIII. we have had little criticism of the scope of the Scheme so far as concerns the persons included in it. Most of the witnesses were, moreover, practically at one in their approval of the present method of deriving the revenue, that is to say, by means of compulsory contributions from employers and workers with a proportionate contribution from the National Exchequer; though it may be observed that the National Confederation of Employers' Organisations pressed strongly for a reduction of the contribution and the assignment of a larger proportion of the cost than hitherto to the State (App. CVII).

The Scale of the Benefits.

25. On the "cash" side, criticism was directed from some quarters towards the present limitation of the money benefits and, in particular, an unfavourable comparison was instituted with the more generous scale of benefit under the Unemployment Insurance Scheme. On the other hand, this view was contested by many substantial witnesses on the grounds that the additional cash benefits now given by many Societies mitigated any insufficiency in the standard rates of benefit, and that, in any case, it was socially desirable to leave part of the field open to be covered by voluntary insurance. The fact that the maternity benefit was almost entirely absorbed by the doctor's or midwife's fees was also the subject of general comment. On the "health" side there was an almost unanimous opinion that extension of the scope of medical benefit to cover something more than general practitioner treatment was desirable and necessary, and many witnesses pressed on us the need for linking up more effectively the medical provision under the Scheme with the numerous other forms of public provision for promoting health and preventing disease. A very large part

of the evidence submitted to us was, on the one hand, concerned with the conditions under which the existing medical benefit could be extended or supplemented by other benefits of a medical nature and, on the other hand, with the possibility of overcoming the lack of co-ordination with which at present the medical services of the country are frequently reproached. The development of maternity benefit from a mere cash payment into an adequate provision of skilled supervision and treatment of mother and child during the period centred on the confinement was urged by numerous witnesses, including several representative bodies devoted specially to the interests of working women. Much emphasis was also laid on the desirability of developing, as far as practicable, the possibilities which the scheme offers for the prevention of illness and the improvement of the general standard of health.

The Inequalities of Benefit.

26. We also received much evidence in criticism of the inequalities of benefit which result from the variations between the valuation surpluses of Approved Societies and of the confusion alleged to be consequent on the comparative freedom which Societies enjoy in selecting and, indeed, in defining the content of additional benefits other than an increase in the rates of the cash benefits. The opinion was freely expressed by certain witnesses that the present arrangements did not result in the fullest advantages being secured to the general body of insured workers in return for the expenditure incurred, and that in a National Scheme supported by uniform contributions compulsorily levied, these wide inequalities of benefit were a serious blemish. Other witnesses, on the other hand, contended vigorously for the maintenance of the present system. In the view of these witnesses the enforcement of a uniform rate of contribution in the case of all insured persons, whatever the differences in their economic conditions or the variations in the risks to which they are subject, occupationally or for other reasons, cannot otherwise be justified. Some of those who advanced this claim relied on pledges given when the Bill of 1911 was before Parliament, to the effect that, to meet this difficulty, insured persons should be free to choose their own Societies and the Societies should have full control of their own surpluses. In this particular sphere, indeed, it became evident that we had to recognise the existence of opposed and apparently irreconcilable opinions held in each case by schools of thought whose views were entitled to respect and consideration.

The Administrative Agencies.

27. Another matter to which much of the evidence was directed was that of the suitability of the Insurance Committees

and the Approved Societies as agencies for the administration of the health and cash benefits, respectively. So far as Approved Societies are concerned, this is not so much one question as a whole group of questions calling for careful consideration from many different angles.

General Satisfaction with the Scheme.

28. All these grounds of criticism, as well as the suggestions received by us in connection with various details of the Scheme and our proposals for its modification and extension, are dealt with in the succeeding chapters of our Report. In this place we have restricted ourselves to a summary mention of these points in order to give a preliminary view of the problems before us. We can, however, say at once that we are satisfied that the Scheme of National Health Insurance has fully justified itself and has, on the whole, been successful in operation. The workers of this country have obtained under it substantial advantages, in particular by securing the title to free medical attention and medicine whenever and as soon as these are required, and by the proportionate diminution, to the extent of the cash benefit granted, of their anxiety as to the loss of wages during illness. Furthermore, the Scheme has, on the whole, been satisfactorily administered, notwithstanding the difficulties and antagonisms at the outset, and the peculiar and urgent problems which arose when vast numbers of men left insurable employment for the theatres of war and their place in the industries of the country was taken by women entering insurance, consequently, for the first time. The contributions have been collected and the benefits provided with a marked degree of efficiency. We are convinced that National Health Insurance has now become a permanent feature of the social system of this country, and should be continued on its present compulsory and contributory basis. At the same time, if the Scheme is to be made of the fullest advantage to the health and well-being of the nation, there are, in our opinion, various modifications and extensions that could, with advantage, be made, as and when opportunity offers and funds become available.

CHAPTER IV.

THE RELATED SCHEMES OF SOCIAL WELFARE.

General Nature of the Evidence.

29. In the very brief summary contained in Chapter II we have described the Health Insurance Scheme viewed as a self-contained system, and have intentionally refrained from looking beyond its borders. Our reference, however, permits and, indeed, requires us to examine the relationship in which the Scheme stands to those other activities of the State which are concerned with the promotion of the health of the nation. We take the view that any element of those other schemes which reacts in a substantial way upon the working of the system of Health Insurance appropriately comes within our purview.

30. Accordingly we have received and considered evidence relating to the various Public Health services as exemplified in the schemes of Maternity and Child Welfare, the arrangements for dealing with infectious diseases, tuberculosis, and venereal diseases, and the work of the Port Sanitary Authorities. All these services have a very direct bearing on National Health Insurance inasmuch as, by removing conditions prejudicial to the health of the community, or by the provision of remedial measures, they tend to diminish the volume of sickness and so to reduce expenditure on sickness and disablement benefits. We have also taken notice of the problems of the Poor Law medical service in its relation to medical benefit, and have considered the extent to which the cash payments provided as sickness and disablement benefit require to be supplemented by the grant of relief under the Poor Law. We have, further, heard evidence as to the system of medical inspection in factories, which is administered by the Home Office; and of medical inspection and treatment in schools, which is supervised by the Board of Education. To a less extent we have considered the Unemployment Insurance Scheme. The main features of that scheme are, of course, outside our reference. But the problems created by the inequality in the rates of cash benefits under the Health and Unemployment Insurance Schemes and the possibility of devising measures to secure from the Employment Exchanges certification of genuine unemployment as evidence for the excusal of arrears under the Health Insurance Scheme, have to a limited extent brought the Unemployment Insurance system under our review.

31. The Ministry of Health have submitted to us (in App. CIV) a statement as to the services concerned with the public health, maternity and child welfare, infectious diseases, tuberculosis, venereal diseases, port sanitation and medical relief and

maintenance under the Poor Law. It will be seen that in that statement there is furnished an account both of the central and the local administrations of these services, and that the costs to the Exchequer and to the local rates are given separately. The Scottish Board of Health have dealt with the corresponding problems in Appendix CV. In Appendix CIX the Board of Education have given an outline of the School Medical Service, and in Sir T. M. Legge's statement (Appendix XLII) will be found an account of the system of medical inspection in factories. We have thought it advisable to supplement most of this material by oral examination, being satisfied in our minds that the inter-relationship of all the health services is one of the most important questions before us.

32. Inasmuch as the descriptive statements referred to above are published in full in the Appendix to the Minutes of Evidence taken before us, it is not necessary to enter into the matter here in any elaborate detail. It may not, however, be out of place to furnish a short summary of each of these services similar in scope to that already given in Chapter II in the case of the Insurance Scheme; and to comment in passing on one or two points of interest which have emerged.

The Central Control.

33. In the first place, it may be observed that unity of administration at the centre is provided for in England and Wales by the single control of all these health services (except the school medical service and the inspection of factories), which is vested in one Department, namely, the Ministry of Health. So far as the schools are concerned, the Department actually supervising the work—the Board of Education—acts in this matter as the agent of the Ministry of Health, and the two Departments have a Chief Medical Officer in common. The Minister of Health, we are informed, has, in fact, in pursuance of a provision in the Ministry of Health Act, 1919, delegated the administrative arrangements to the Board, which continues to act subject to the suzerainty of the Minister. We were assured in evidence that effective co-ordination at the centre has been secured and that the high intentions with which the Ministry of Health was established have, so far as six years allow, not remained without fulfilment. We may quote the following extracts from the Evidence. "There is a very considerable measure of co-ordination by means of frequent consultations between the various heads of the Divisions as well as by reason of there being one Minister and one Permanent Secretary in the Ministry to whom all the heads of the Divisions are responsible." (*Kinnear*, Q.24,199.) "The arrangements for co-ordinating the work of the Ministry are such, I think, as to secure a continuance of this process as opportunity arises." (*Kinnear*, Q. 24,211.)

The Local Systems of Administration.

34. When, however, we turn to a consideration of the local administration of these health services we find a multiplication of local administrative bodies and a considerable division of functions due to some extent no doubt to historical causes. It is true that the work relating to public health, maternity and child welfare, tuberculosis, and venereal diseases are controlled by one local authority and administered under one chief executive officer, namely, the Medical Officer of Health. But there remain under other independent local authorities the school medical service, the Poor Law medical service, the Insurance Service and in certain cases the Port Sanitary service. Further the medical inspection of factories stands outside the supervision of any local authority. The problems raised by the Port Sanitary service appear to be of such a special nature that probably nothing is lost by the existence of a separate authority, though in point of fact the Local Authority in certain cases also acts as the Port Sanitary Authority. Where, however, as often happens, the natural port area covers several municipal areas a joint and specially constituted authority is necessary. The administration of the school medical service stands, of course, in the closest relationship to the educational work of the local Education Authority, under whose direct control it is placed. The systems under which medical provision is made locally for the sick poor and for the insured population are entirely separate from each other, both in administration and in the financial arrangements which they require, the one being supported by the local rates and the other by the contributions of the workers and their employers supplemented by grants from the Exchequer. Each, however, must be locally managed and in respect of each the present method of administration must shortly come under review, the first in connexion with the pending reform of the Poor Law, and the second as a consequence of recommendations which we have decided to make and to which we refer at some length in a later chapter. The question naturally arises whether in the course of developments in these directions, an opportunity will arise to effect a measure of local unification which in the circumstances would be considerable in its scope and consequences. We note the possibilities in this respect, though it does not fall to us to consider them in any detailed manner.

35. We now proceed to give a very brief outline of the various services under review.

Tuberculosis.

36. The national scheme for the treatment of tuberculosis is administered locally by the Councils of Counties and County

Boroughs, who submit to the Minister schemes for the treatment of persons suffering from tuberculosis at or in dispensaries, sanatoria and other institutions. The Local Authorities in this matter deal with all classes of persons, insured and uninsured. In addition to the service given in the tuberculosis dispensaries and the sanatoria and hospitals, home-visiting by tuberculosis nurses and health visitors, and extra nourishment for tuberculous patients receiving treatment at home, are provided. Schemes are in operation in every County and County Borough, and the total number of approved tuberculosis dispensaries in England is 454, under the charge of 353 Tuberculosis Officers. The number of residential institutions is 458, containing nearly 21,000 beds. Of these beds 13,000 are in institutions belonging to Local Authorities and 8,000 in institutions belonging to voluntary bodies. The gross expenditure on all this work was in 1922-23 about £2,600,000, of which about £1,600,000 was met from Exchequer grants, the remainder being, in large part, borne by the local rates. At present the distribution of the burden between the Exchequer and the Local Authorities is on the basis of an annual State grant of £315,000, in addition to an annual grant of 50 per cent. of the approved net expenditure incurred by Local Authorities. Provision is also made for the treatment of ex-service men suffering from tuberculosis, attributable to or aggravated by service in the War, and, through the Ministry of Pensions, arrangements are made for defraying the cost of treatment so given.

Venereal Diseases.

37. Treatment centres for venereal disease are established throughout the country at which all persons may obtain treatment free of cost under conditions of secrecy. Facilities for the diagnosis of venereal disease by laboratory methods are made available free of cost not only to the medical officers of the Treatment Centres, but to medical practitioners in general. A gratuitous supply of approved arsenobenzol compounds is made to medical practitioners who possess one or other of certain specified qualifications; and propaganda as to the dangers of venereal disease and the necessity for treatment is conducted. These schemes are carried out by the Councils of Counties and County Boroughs with the aid of a Government grant of 75 per cent. of the approved expenditure, the remainder being borne by the rates. There are in England and Wales about 194 of these treatment centres. The annual expenditure of Local Authorities on this service is about £420,000. The propaganda work is undertaken by the British Social Hygiene Council on behalf of the Ministry of Health, and involves an expenditure of about £6,700 a year, the whole of which is borne by the Exchequer. The Local Authorities also carry on propaganda work.

Maternity and Child Welfare.

38. Maternity and Child Welfare schemes are conducted by County Councils and County Borough Councils and the Councils of certain of the larger County districts. Amongst the services for which the schemes provide are included the salaries and expenses of inspectors of midwives, health visitors and nurses engaged in maternity and child welfare work, the provision of midwives for necessitous women in confinement, and the expenses of Centres, *i.e.*, institutions providing any or all of the following activities: medical supervision and advice for expectant and nursing mothers, and for children under five years of age, and medical treatment.

39. The expenditure on these services is met by a 50 per cent grant from the Exchequer, the balance being found from the rates; and the grant is made on condition that the work of the agency is co-ordinated, as far as practicable, with the Public Health work of the Local Authority. The total Exchequer grant paid to Local Authorities and Voluntary Agencies was in 1922-23 about £785,000. The total expenditure on the whole service amounted to about £1,530,000 in 1922-23.

Port Sanitation.

40. The primary object of the Port Sanitary Service is to protect this country and British shipping from the introduction of grave infectious diseases which are endemic in certain parts of the world but are not ordinarily found in this country, for example, plague, cholera, yellow fever and in a lesser degree typhus fever and small-pox. Constant inspection and supervision of shipping is carried out to this end, and in the course thereof, all cases of ordinary infectious disease which are discovered are also dealt with. Efforts are likewise made to secure healthy conditions on board ship. The other main branch of port sanitary administration is the inspection of food entering the country in bulk.

41. The total annual expenditure of the Port Sanitary Authorities in England and Wales amounts to about £90,000, and an Exchequer grant is made amounting to 50 per cent. of the approved net expenditure.

Infectious Diseases.

42. The control and treatment of acute infectious diseases, such as scarlet fever, diphtheria and small-pox, is carried out in the main by the local sanitary authorities without assistance from Government funds. Broadly speaking, the functions of the sanitary authorities in respect of infectious disease are:—

(1) To receive from medical practitioners in their district notification of cases of certain infectious diseases. Inquiries

are then made to discover the source of infection and to ensure that all precautions desirable to prevent the further spread of infection are taken. Occasionally these inquiries disclose an urgent need for wide investigation and prompt action, as for instance where there is reason to suspect that water supplies, milk supplies, or oyster layings have become contaminated. The Medical Officer of Health is prepared to assist a medical practitioner in the diagnosis of a dangerous disease, such as smallpox, if requested.

(2) To provide facilities for the isolation and treatment in hospital of persons suffering from acute infectious diseases who cannot be properly isolated and treated at home. The powers of Section 131 of the Public Health Act, 1875, to provide isolation hospitals are permissive and not mandatory, and some districts are still without any means of isolating cases of infectious disease. Provision is made in the Public Health Acts and in the Isolation Hospitals Acts for the formation of Joint Boards or Joint Committees for the purpose of providing and maintaining hospitals for the common use of two or more sanitary districts, and the Minister of Health has, in some instances, made regulations under Section 2 of the Public Health (Prevention and Treatment of Diseases) Act, 1913, authorising a County Council to provide an isolation hospital for the whole or part of the County

43. In the year 1921-22 expenditure on the provision and maintenance of isolation hospitals amounted to about £4,320,000, of which only about £4,200 was met out of Exchequer grants.

The School Medical Service.

44. Passing now to the school medical service we find that the authorities responsible for this administration are the Local Education Authorities which are the Councils of all Counties and County Boroughs and of certain non-County Boroughs and Urban Districts. These Authorities exercise their powers in all cases through statutory Committees appointed for the purpose. All school children are medically examined at entrance to school, at the age of 8, and at the age of 12, on the basis of a model schedule issued by the Board of Education, which is in general use in nearly every area. Any children who appear at any time to be ailing are also submitted to medical examination, and any child in whom a defect is found is reinspected subsequently. In such cases the parents are informed and are advised to have the defect remedied, and school nurses follow up the cases to see that the necessary treatment is provided. The parents are expected, if able to do so, to provide the treatment themselves, but where they are unable, for any reason, to secure the necessary treatment, the Local Education Authority provides treatment for the following types of defect: minor ail-

ments, defects of vision, defects of teeth, enlarged tonsils and adenoids and crippling defects.

45. The School Medical Service thus keeps the whole school population under constant medical supervision, brings to the notice of parents defects from which their children are suffering and urges the necessary remedies. Further, it provides certain definite forms of treatment itself. Each Authority has a School Medical Officer in charge of the work, with one or more medical assistants for the ordinary duties. In addition the Authorities employ specialist officers, either whole-time or part-time, for certain branches of the work, such as dentistry, care of the eyes, and operative treatment.

Medical Service of the Poor.

46. Coming now to the Poor Law Medical Service, we find that the regulations of the Central Authority require that every Board of Guardians shall provide an outdoor medical service and an institutional medical service for the destitute poor. For the former purpose there is appointed in each district a medical officer, whose duty it is to attend, and supply medicines to, all poor persons requiring medical attendance within the district at the order of the Guardians or the Relieving Officer. These medical officers are general practitioners and are usually on the insurance panel. For the purpose of institutional medical service there is the staff of medical officers and nurses attached to the workhouse infirmaries. There are at present in England and Wales 635 Boards of Guardians managing 629 workhouses, 597 of which include at least some accommodation for the sick. There are also 71 separate institutions for the sick and 16 institutions for defectives. The total number of Poor Law beds provided expressly for physical or mental infirmity may be taken as roughly 129,000, of which 37,000 are in separate hospitals and infirmaries and 13,000 in separate institutions for mental cases. The total number of persons suffering from sickness, accident or bodily infirmity in receipt of Poor Law medical relief on 1st January, 1925, was about 310,000. The estimated expenditure by Boards of Guardians in 1923-24 on persons suffering from bodily infirmity was about £7,000,000, of which over £6,000,000 was borne by the rates, the remainder being met from the small Exchequer grant and other receipts.

Medical Inspection in Factories.

47. The arrangements for medical inspection in factories and workshops are made directly by the Home Office, and Local Authorities have no place in the scheme. From Sir T. Legge's

statement (Appendix XLII) it may be inferred that, while this long-established system works successfully, he feels there may be room for some closer relationship between the medical work of his Department and the other medical activities of the local bodies and of the insurance practitioners. But while the problems of ill-health in factories have, no doubt, some relation to the general sanitary conditions of the area and to the work of the ordinary practitioners, we understand that there are strong arguments for retaining the existing close connexion between the medical and the technical inspection of factories. In reply to questions on this matter, Mr Brock expressed the view of the Ministry of Health as follows: "It was felt that the practical difficulty of transferring medical inspection of factories to the Ministry arose from the impossibility of divorcing it from the general work of factory inspection. In practice it would be very difficult to separate the medical side from questions of Workmen's Compensation and from the lay factory inspection as distinct from the medical inspection." (Q. 24,183). "I think the medical inspection of factories involves so many questions of a technical and not wholly medical character that it would be very difficult to separate it from the general provision for factory inspection." (Q. 24,184.)

The Contributory Pensions Scheme.

48. As to the relations of the Health Insurance Scheme to the arrangements under the Widows', Orphans' and Old Age Contributory Pensions Act recently passed little need be said. The provisions for the joint stamp and joint collection of contributions are matters of machinery. On the benefit side the two schemes stand quite apart. The age limit for contributions and cash benefits under the Health Insurance Scheme is to be lowered from 70 to 65 as from January, 1928, and the weekly contribution payable is accordingly reduced by 1d. in the case of men and $\frac{1}{2}d.$ in the case of women. Medical benefit, as before, does not cease when the insured person's rights to cash benefits under the Act are terminated at 65, but continues throughout the remainder of life.

Workmen's Compensation.

49. The payment of benefit to persons in receipt of compensation under the Workmen's Compensation Acts is dealt with in Section 16 of the National Health Insurance Act of 1924. If the weekly value or weekly rate of the compensation received is equal to or exceeds the weekly rate of Health Insurance benefit to which the insured person would otherwise be entitled, no benefit is payable. If it is less only the difference is payable. Lump sum compensations are to be translated into weekly

equivalents for this purpose. The relief to the insurance funds thus resulting is allowed for in the actuarial calculation of the contribution. The system appears to work well and has the feature that it continues to place upon the employers the full financial responsibility for industrial accident and disease.

Maintenance of the Poor.

50. Turning to the maintenance aspect of the Poor Law, we have had evidence as to the supplementing of the cash benefits under the National Health Insurance Scheme by Poor Law relief. The Scottish Board of Health submitted a statement showing the numbers of persons in certain industrial parishes who applied for Poor Relief to supplement National Health Insurance Benefit and other resources, and stated that, from information based on the Census records, " The indications are that for both sexes, 5·9 per cent., and for men, 7·3 per cent., of the insured persons drawing benefit applied for poor relief (App. CV, 51). The evidence furnished to us by the Ministry of Health indicates that while " no records are available of the number of applicants for, or recipients of, Poor Law relief who are insured persons, it can only be stated that the proportion must be a substantial one." The evidence from this quarter also indicates that in the two Boroughs of Reading and Halifax it was reported that 9·3 per cent. and 3·4 per cent. respectively of the persons in receipt of Health Insurance Benefit on a certain date were also in receipt of Outdoor Relief (Appendix CIV, 69). The Association of Poor Law Unions of England and Wales informed us that " an insured person in receipt of sickness benefit comes to the Guardians for help simply because he has some dependants. He is thrown out of work and there is nothing coming in except his sickness or disablement benefit. In a case like that they are bound to come for Poor Law assistance unless they have some other resources " (Q. 21,673).

51. This evidence raises the fundamental principle involved in the question whether these benefits should be adequate for maintenance, or whether their supplementation by private insurance in the case of the provident and by the Poor Law in the case of the thriftless or unfortunate is to be regarded as a permanent and desirable element in the system. The present rate of 7*s.* 6*d.* a week for disablement benefit is obviously not sufficient for the maintenance even of the single man. It was probably never intended to be, but was merely a basic sum such as the contribution could provide, giving an assured though small weekly payment which could be supplemented by private savings, voluntary insurance, and in other ways. The sickness benefit of 15*s.* is very near the margin for the single man and insufficient for the man with dependants. It is true that the

grant of additional cash benefits, which may raise the former rate to 10*s.* and the latter to 20*s.*, may make such supplementation less necessary. But these additions are not universally operative, and many Societies do in fact give their members cash benefits at the basic rates only.

The Unemployment Insurance Benefits.

52. In this connection we may be permitted to refer to certain disparities between the Health and the Unemployment Insurance Schemes. In the latter the standard rate of benefit is 18*s.* a week, and additions of 5*s.* are made for the wife and 2*s.* for each dependent child. It is difficult, in our opinion, to justify a less generous provision for the invalid than for the man in good health, whose circumstances certainly involve smaller expenditure. It is equally difficult to justify the existence of two State schemes side by side, one of which recognises the needs of dependants and the other does not, in circumstances of hardship closely similar. Both schemes are designed to alleviate the distress arising from the cessation of income due to causes beyond the worker's control, and the question whether these causes are to be sought in ill-health or in the failure of employment has no bearing on the needs of dependants.

It has been suggested to us by the National Association of Trade Union Approved Societies that, as a consequence of the higher rate of unemployment benefit there may be a temptation to apply for that benefit rather than for sickness benefit, even though the applicant may be incapable of work, and so fulfil the statutory condition for the latter. (Appendix XCII, 109.) In such a case he would, of course, be really disentitled to receive unemployment benefit. We have received no direct evidence on the point and, in any case, such evidence would probably be difficult to obtain. We do not doubt that this question, which primarily affects the administration of Unemployment Insurance, is fully in the minds of the officials of the Ministry of Labour.

Certification of Unemployment.

53. It has been suggested to us that the machinery of the Employment Exchanges should be utilised to certify genuine unemployment with a view to excusal of arrears under Health Insurance. We are impressed with this possibility, and have received evidence from the Ministry of Labour on the subject (App. CII, Q. 23,290 to 23,395). The question arises whether, in a period of widespread unemployment, arrears of contributions due to this cause should penalise the insured person in respect of benefits granted under the Health Insurance Scheme. While it is true that the Prolongation of Insurance Act and the present Arrears Regulations make a temporary and partial provision for

this difficulty, we are inclined to think that some arrangement to excuse arrears in respect of genuine and, as far as possible, officially certified unemployment should be part of the permanent scheme, and we deal with this problem in Chapter XIII.

54. We have in this chapter merely attempted to indicate broadly the nature and extent of the territories lying along the borders of Health Insurance. We reserve for a later chapter our detailed consideration of certain questions which arise from a consideration of the relations of the Health Insurance Scheme to these other activities of the State.

CHAPTER V.

THE DEVELOPMENT OF THE HEALTH SERVICES.

55. We propose to devote this chapter to a consideration of the medical aspects of the Health Insurance Scheme in their relation to the various other health services organised or supported by the State which we have described in the preceding chapter. For this purpose we have felt justified in assuming that the various health services of a public character will continue to expand both in their scope and in the range of persons to whom they apply; and that while the limitations of finance to which we refer in Chapter VI may prevent development in the near future, yet, as time passes, these may become less restrictive. It also appears to us that we may accept as a principle which should govern any such developments, the desirability of bringing into closer relationship the various services directed towards the prevention of sickness and the improvement of health, and that the organisation of the services should be such as to facilitate those developments which from time to time may become possible.

56. Medical benefit has been in operation for 13 years; of the other branches of medical service some preceded, others followed its introduction. In all these activities we have found, speaking broadly and with full consciousness of its limitations, such a contribution to the health and well-being of the community that we feel sure that a steady expansion in these services will mark our future social history. We will first devote some space to a consideration of what medical benefit is and what its practical results have been, as from the point of view of our reference that benefit must occupy the central position in a survey of the health services.

SECTION A.—MEDICAL BENEFIT.

Scope of Medical Benefit.

57. Medical benefit is defined under Section 10 of the 1924 Act as "medical treatment and attendance," which "includes the provision of proper and sufficient medicines and of the prescribed medical and surgical appliances, but does not include treatment or attendance in respect of a confinement."

58. So far as the supply of drugs is concerned, there is, subject to a safeguarding provision directed against extravagant prescribing, no limit in nature or cost to what the doctor may in his discretion prescribe. But as to the service he gives, the scope of the benefit has in practice been limited to such treatment as may reasonably be regarded as within the competence of

a general practitioner. The definition given in the Regulations now in force is as follows :—

> " The treatment which a practitioner is required to give to his patients comprises all proper and necessary medical services other than those involving the application of special skill and experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess." (Clause 8 (1) of Part I of the First Schedule to the Medical Benefit Consolidated Regulations, 1924).

59. We were so much impressed by this limitation—imposed as it was by regulations and not explicitly in the Act itself—that we examined the official witnesses of the Ministry of Health on the point at some length. We were told (*Brock*, Q. 995) that the apparently narrow view taken was based on the advice given to the Insurance Commissioners by their legal advisers at the inception of the Scheme. This was to the effect that the provisions of Section 24 of the 1924 Act (Section 15 of the 1911 Act) were not consistent with any other view. The Act gave every duly qualified medical practitioner a right to come upon the medical list, and it contemplated that every insured person would have one medical attendant but not more than one at a time, and that if the insured person did not himself choose a doctor, he might after a certain time be allocated to a doctor by the local Insurance Committee. Thus the effect of the provisions of the Act was that the insured person was entitled to receive from one doctor, and from one doctor only, the whole of " medical benefit " whatever that phrase might mean. In these circumstances it appeared to the legal advisers and to the Department that the scope of medical benefit must be construed as limited to services within the competence of the average general practitioner. Further, though the medical lists included a certain number of men with special experience, whose competence in certain directions was therefore above the average, it was felt that if all doctors were to receive the same rate of remuneration, as practical considerations were found to require, a uniform obligation and a uniform content of service were implied; and that it would not be equitable to require one man, because he happened to possess some special skill, to render a wider range of service than was required from the majority of his fellow practitioners engaged under the insurance contract.

60. Though this limitation of the service has been from time to time commented upon (see *Brock* and *Smith Whitaker*, Q. 1080-1101) and though on all sides a fuller conception of medical benefit has been urged upon us by witnesses, no attempt to challenge it in the Courts has ever been made during the 13 years of its operation. We may fairly assume, therefore, that it is valid on legal grounds and we recognise the general and

administrative reasons for the restrictions contained in the Regulations.

Evidence Supporting Extension.

61. That an extension of the scope of the service is widely desired has been made abundantly clear to us in evidence. Witnesses appearing before us on behalf of the Ministry of Health and the Scottish Board of Health, informed us that " the trouble that has always been brought home to us about medical benefit is that the absence of a specialist service is treated as a reproach " (*Smith Whitaker*, Q. 24,024). " Informed public opinion in Scotland in relation to health services . . . is, broadly speaking, that . . . the present insurance service, as far as it relates to health, is defective, and that the present medical service is merely a general practitioner service; and that in order to get the full benefit of the Scheme . . . it is imperative . . . to extend that service to include . . . all proper aids to diagnosis, all second opinions in the way of experts . . . and certain services which we might broadly describe as curative . . . as electrical treatment, light treatment, and so on " (*Leishman*, Q. 24,328). The British Medical Association (App. XLVII, 19-20, Q. 14,972-14,974) state that " the medical provision made for all persons included in the Scheme should be as far as possible complete." " It is desired to make all such services and benefits (i.e., the various services provided by the Public Health and Education Authorities) an integral part of the Insurance Scheme . . . and to extend the provision so as to include complete consultant and specialist advice and treatment, full laboratory facilities for clinical purposes, residential institutional treatment . . . dental advice and treatment, such ancillary help as can be given by nurses and masseurs, and an ambulance service. . . . The Association is of opinion that all these benefits should be equally available to all insured persons alike, regardless of their membership of any particular Society."

62. The Medical Practitioners' Union (App. XLVIII, 13, Q. 15,345-15,346) hold that " it is right and proper that the provision of medical services by the State should extend until the widest possible benefits of preventive and curative medicine are available for those persons who, without State assistance, would be unable to obtain them." The Society of Medical Officers of Health (App. LVI, 10, Q. 16,993-16,994) urge that " a commencement should be made to give medical benefit its true meaning by including (*a*) facilities to the medical profession for laboratory diagnosis; (*b*) specialist advice and treatment; (*c*) dental treatment; (*d*) treatment in general hospitals and other like institutions; (*e*) further accommodation for the treatment of tuberculosis, especially surgical tuberculosis;

(*f*) treatment in convalescent homes; (*g*) home-nursing when required; (*h*) all other necessary medical advice and treatment." Dr. Harry Roberts, a practitioner in the East End of London with a large insurance practice, gave similar evidence which impressed us both by its quality and as representing the considered views of one who is in close daily contact with the problem in its most difficult form. He refers (App. LI, 14, Q. 16,117) to " the limitation of provided medical treatment to such as is assumed to be within the range of an average general practitioner " as being " one of the principal limitations of utility of the present medical service."

63. Other medical bodies and practitioners have spoken before us to the same effect, and it is evident that the weight of the professional evidence is in favour of a removal of the restriction which seems to be inherent in the arrangements under the present Statute.

64. Turning to the non-professional witnesses we find the same trend of opinion very strongly indicated. The Hearts of Oak Benefit Society (App. IV, 254, Q. 3544-3546) recommend the inclusion of a specialist medical service as part of medical benefit, and (App. IV, 284, Q. 3549-3551) the provision of at least 50 per cent. of the cost of dental benefit for all insured persons. The Ancient Order of Foresters (App. V, 37-44; 46-49) and the Independent Order of Oddfellows (Manchester Unity) (App. VII, 53-61) make similar recommendations.

65. The Joint Committee of Approved Societies state (App. XIV, 24, Q. 8723) that they " desire to see the benefit given by the Act of 1911 fully conferred upon the insured, i.e., adequate medical attendance and treatment and not the restricted form of (domiciliary) medical benefit defined by the Regulations." The National Conference of Friendly Societies, representing over four million insured persons, urge (App. XXVI, 22, Q. 10,913-20) that " until a public medical service can be instituted medical benefit should be extended to include the provision of specialist and consultant services." The National Association of Trade Union Approved Societies submit (App. XCII, 94) " that the term ' medical benefit ' should mean everything that medical and surgical science can command for the prevention or cure of sickness." The evidence from Insurance Committees and their representative bodies is to the same effect. Witnesses giving evidence before us on behalf of the Central Departments also agreed as to the desirability of extending the provision so as to include a specialist and consultant service if the difficulties of finance could be overcome. (See *Kinnear*, Q. 23,682-23,686; *Leishman*, Q. 24,337-24,340.) Finally we may quote an extract from the Annual Report of the Chief Medical Officer of the Ministry of Health, 1924 (p. 163). In concluding his survey

of the insurance medical service and speaking of the work of the insurance practitioner he says :—

> "The work is carried out under certain disadvantages, chief among which is the lack of co-ordination between the services of the insurance doctor and those of workers who have devoted intensive study to special provinces of the great territory of medical practice. The inclusion of such consultant services becomes more and more requisite year by year and is one of the most pressing of present needs. When the insurance medical service shall have been completed by being brought into organic relation with other branches of medical work as part of a comprehensive scheme of medical services, and not until then, will its full capacity for public usefulness be made manifest."

66. We have devoted some space to this question, not only because we think it is of the highest importance in the Scheme as it stands and in relation to the various and widely different proposals for extension and reform which have been put forward, but also because we feel that it raises a cognate question of great difficulty. If medical benefit were thus extended for the present insured class, we are forced to consider the position of those persons of moderate means who are somewhat above the present income limit for insurance purposes but to whom the payment of a specialist's or consultant's fees is nevertheless a serious matter. It is assumed, probably rightly, that such persons can reasonably be expected to meet charges for general practitioner treatment, and are therefore properly excluded from the Scheme in its present form. But in respect of major operations and similar services, for which it is usually necessary that the patient should be an inmate of a hospital or similar institution, it might with reason be contended that the claim which could be advanced on behalf of some of these persons to be protected by some form of State insurance against the risks involved is scarcely, if at all, less valid than the claim of certain of the insured population, and that to provide a full specialist service for the insured, while leaving these adjacent classes to their own resources would bring about a position difficult to justify on grounds of public policy. This point of view was put before us by the National Association of Trade Union Approved Societies, who submitted "that if the difficulties connected with the collection of contributions can be surmounted, medical benefit should be available to persons not employed within the meaning of the Act, whose total income does not exceed £350 a year, and that medical benefit other than general practitioner treatment should be provided for persons whose income exceeds £350 a year, but does not exceed a higher figure to be determined later. . . . ." (App. XCII, 102.) We desire to emphasise in the present discussion of the scope of medical benefit the problem of specialist services for the non-insured of

moderate means, because it is one to which we have felt it necessary to have regard in a later chapter of our Report.

The Value of Medical Benefit.

67. We come now to the question of the value of medical benefit within the limitation we have just discussed. Such as it is, it has been available for 13 years. It is now provided for about 15 million people and costs the Insurance Funds about £9¼ millions a year, of which about £7¼ millions goes to the doctors and nearly £2 millions on the provision of drugs and appliances. We are told that the number of persons attended in a year may be taken at roughly 7½ millions, the attendances at 52 millions, and the number of prescriptions at between 40 and 50 millions. This service is provided by nearly 15,000 doctors and over 10,000 chemists. These figures sufficiently indicate the enormous volume of the work under the State scheme initiated in 1912, and the social results may, we think, be inferred. The benefit indeed has set up a "new model" in medical provision for the workers, with which the club practices and Friendly Society arrangements of pre-insurance days are scarcely comparable either in extent or quality.

68. As to the quality of the insurance medical service we will restrict ourselves to a citation of some representative extracts from the evidence, prefacing these quotations with the remark that the general acceptance of the system during the last 13 years, the absence of any substantial volume of criticism of it apart from the question of scope already referred to, and the wide demand for its extension, are in themselves evidence of a favourable kind.

Independent Order of Oddfellows (Manchester Unity).—"The present system of providing medical benefit through panel practitioners should be continued" (App. VII, 59).

Independent Order of Rechabites.—"It can almost unreservedly be said that our relations with the medical profession have been most cordial, and recorded cases of complaint have been very few indeed" (App. VIII, 25). "The present panel service deserves more commendation than it sometimes gets" (Q. 4130).

Mr. Alban Gordon.—"I am not prepared to contend that it (the Insurance Medical Service) does not possess as high a standard of efficiency as can reasonably be expected within the bounds at present set" (App. XIII, 32).

The Coventry Insurance Committee.—"The general practitioner service is adequate, and the Committee have only dealt with 15 complaints against doctors since 1912. It is believed that the dispensing service is adequate and popular—practically no

complaints arise " (App. XXXIII, 24 and 26). " In the majority of cases the doctors take very great pains to give a willing and conscientious service " (Q. 12,297).

Ministry of Health Inquiry Room.—" Surprisingly few complaints against the medical service are received, although the object of these visits (i.e., of visitors to the Inquiry Room) is to bring forward an insurance grievance. . . . With very few exceptions those persons who speak to the detriment of the insurance medical service have never been under the treatment of a panel practitioner " (App. XLI, 14).

The Standing Committee of Scottish Insured Women.—" The Committee regards medical benefit as the most important benefit under the National Health Insurance Act " (App. XLVI, 18).

The British Medical Association.—" In the year 1922 both the Representative Body of the Association and the Conference of representatives of Local Medical and Panel Committees declared that the measure of success which has attended the experiment of providing medical benefit under the National Health Insurance Act system has been sufficient to justify the profession in uniting to ensure the continuance and improvement of an Insurance system.

(*a*) Large numbers, indeed whole classes of persons are now receiving a real medical attention which they formerly did not receive at all.

(*b*) The number of practitioners in proportion to the population in densely populated areas has increased.

(*c*) The amount and character of the medical attention given is superior to that formerly given in the best of the old clubs, and immensely superior to that given in the great majority of the clubs which were far from the best.

(*d*) Illness is now coming under skilled observation and treatment at an earlier stage than was formerly the case.

(*e*) Speaking generally, the work of practitioners has been given a bias towards prevention which was formerly not so marked.

(*f*) Clinical records have been or are being provided which may be made of great service in relation to medical research and public health.

(*g*) Co-operation among practitioners is being encouraged to an increasing degree.

(*h*) There is now a more marked recognition than formerly of the collective responsibility of the profession to the community in respect of all health matters."

The Association add that " all these are immense gains, and though it is possible that some of them may not be wholly due to the establishment of the National Health Insurance Scheme, they have certainly been hastened and intensified by that system " (App. XLVII, 5 and 6; Q. 14,613-14,615).

Dr. Harry Roberts.—" In my experience there can be no question as to the enormous advantage to insured persons resulting from the medical provisions of the Insurance Act " (App. LI, 5; Q. 16,136).

The Retail Pharmacists' Union.—" Taking into consideration the enormous number of prescriptions dispensed, and bearing in mind that in no sense is an insured person obliged to go to any particular chemist, the number of complaints against the chemists' service has been almost negligible " (App. LXV, 21). " From every point of view the arrangements for the supply of drugs and appliances through chemists have been successful. . . . Insured persons have benefited very greatly by the arrangements for medical benefit " (App. LXV, 79, 81).

The General Council of Panel Chemists (Scotland).—" The relationship between practitioners and pharmacists is one of mutual respect and confidence and helpful co-operation. The matters . . . . needing amendment are relatively few and are mentioned with a view to their elimination so that a service already on the whole satisfactory may be brought still nearer to the ultimate ideal " (App. LXIX, 28).

The Sons of Temperance Friendly Society.—" The medical service rendered by panel practitioners is considered generally satisfactory so far as it may be given within the definition of range of service " (App. LXXXIX, 41). " The medical service has improved very much upon what it was originally . . . I believe the medical profession as a whole are doing the best they can for insured persons " (Q. 21,534).

The National Association of Trade Union Approved Societies.—" The Medical Profession as a whole has rendered competent and conscientious service to insured persons " (App. XCII, 76; Q. 22,039).

69. Adverse criticisms of the system have naturally been received (see e.g., National Medical Union, App. XLIX and Scottish Medical Guild, App. L), but the examination of witnesses did not convince us that, in the system taken as a whole, there is anything seriously amiss apart, of course, from the limitation of the scope of the benefit, with which we have already dealt. Some reference was also made by certain witnesses (Joint Committee of Approved Societies, Q. 8026-8028, 8040-8041) to the standard of the Insurance Medical Service in London, which was stated to compare disadvantageously with that throughout the country as a whole. We questioned the representative of the London Insurance Committee on the subject (Q. 22,842, 22,899-22,900), but we were not able to obtain any specific evidence as to the foundation on which this general impression of the inferiority of the service in London was based. We may, however, refer in this connexion to the statement of Mr. Brock

(Q. 1051) as to the special conditions in certain districts such as Chelsea and Kensington, and to the very interesting suggestions of the British Medical Association as to possible explanations (Q. 14,623-14,658).

70. We also think it desirable to direct attention to the criticisms made by the Incorporated Society of Pharmacy and Drug Store Proprietors on the pricing of drugs, which are submitted in Appendix LXVI, paragraphs 11-16, and Q. 18,275 to 18,312. This criticism caused us some concern, especially as none of the other professional bodies directed our attention to these matters. We took opportunity later to examine the representatives of the Ministry of Health on the question. (See *Brock* and *Smith Whitaker*, Q. 23,872-23,890.) The representatives of the Incorporated Society appear to have exaggerated the defects in the Drug Pricing procedure, and we are glad to be reassured that the arrangements are as satisfactory as can be expected in dealing with the widely varying systems of supply of drugs and in adapting the tariff to the fluctuations of the commercial market.

71. We may complete this part of the subject by a reference to the volume of individual complaints dealt with under the elaborate machinery set up for that purpose. The following quotations from the evidence of the Federation Committee of the English, Scottish and Welsh Associations of Insurance Committees may be taken as fairly representing the position :—

> " All reports of the Services Sub-Committees have since April, 1920, been sent by Insurance Committees to the Ministry and during that period about 1,700 cases have been investigated, the number for 1923 being 411, representing 3·4 per hundred doctors or per 100,000 insured persons " (App. XXXVI, 116). " Complaints against chemists are very rare indeed " (App. XXXVI, 118). " While there are instances of dereliction of duty in individual cases, the insurance medical and pharmaceutical services can in the main be regarded as efficient " (App. XXXVI, 122).

Private and Insurance Service.

72. We turn now to a subject on which there has been, and may still be, a certain amount of public misgiving. We refer to the suggestion frequently made in the early days of the scheme and still heard occasionally, that doctors and chemists deliberately give to insured persons a service inferior to that given to their private patients. We have questioned many witnesses on this matter, e.g., see *Brock*, Q. 1051-3; *Ancient Order of Foresters*, Q. 4111; *Cheshire Insurance Committee*, Q. 12,465; *British Medical Association*, Q. 14,620-14,622; *Roberts*, Q. 16,101. We are glad to say that, except for some rather contradictory evidence given by witnesses from the National Conference

of Friendly Societies (Q.11,004-11,011), we have found no support for this allegation. On the contrary, there has been a great body of evidence not only from the interested parties—the doctors and chemists—but from Societies and representative bodies showing that no such distinction is made. There is, we need hardly say, no justification for such a distinction in the Act or the Regulations, and any practitioner or chemist deliberately differentiating between insurance and private patients in this way would be subject to disciplinary action. As this is a matter which from time to time engages the attention of the public, a few general observations may, perhaps, be permissible.

73. The assertion that doctors are comparatively inattentive to their insurance patients—a statement more common in unrestrained conversation and in letters to the Press than in formal evidence—is peculiarly difficult to test, inasmuch as, in the nature of things, it almost necessarily rests on vague impressions or sporadic and unrepresentative incidents. It is, perhaps, proper to observe that in a service comprising 15,000 doctors it is impossible to postulate that all will, at all times and in all circumstances, maintain a superlative standard of efficiency and care. It must needs that offences come. The medical profession, like every other craft and calling, can claim no immunity from the intrusion of undesirable and unworthy elements. Nor does this imply any disrespect towards an honourable profession; it is merely an acknowledgment of their common humanity. Isolated cases of negligence and carelessness, therefore, prove nothing; such occur in private practice also. Even if it were established statistically that there were proportionately more causes of complaint in insurance practice than in private practice, this, again, would in itself prove nothing. The causes of complaint might be due to the industrial or social peculiarities of certain areas or to the idiosyncracies of certain doctors, and these might manifest themselves irrespective of the arrangements under which the doctor was giving his service. As against the rather vague suggestions that have been made, it is only right to refer to one other consideration put in evidence before us, namely, that there is a growing tendency among practitioners to be more scrupulous to avoid giving offence in the case of insurance patients than in the case of private patients, since the former are, in a sense, protected by the machinery under the Act for the investigation of complaints. (*Brock*, Q. 1051.) We suggest, finally, that the only satisfactory evidence available is that which expresses the views of those who have seen the operation of medical benefit at close quarters and who, having seen it in bulk, are unlikely to be unduly influenced by any random deviation from the general standard such as is apt to sway the judgment of those less intimately informed on these matters. Of such a character are the views we have already quoted.

74. When we contrast the attitude assumed in 1912 by the medical profession and by considerable bodies of public opinion towards the medical service proposed under the Insurance Act with the body of testimony which we have now received, we can say confidently that adverse forecasts have been falsified and that medical benefit has proved in practice a successful and most valued factor in the advancement of the health of the nation.

75. Before passing from this general discussion of medical benefit as it is at present provided under the Insurance Scheme, we may mention that in Chapter X we make important proposals for an immediate expansion of the scope of the benefit so as to cover expert out-patient services. Much of what we have said here, and especially our review of the relative evidence, should be borne in mind in considering the proposals in question. We have preferred to survey the evidence at this point in connexion with our general examination of the Health Services, though it is, of course, equally relevant to the specific proposals which we later put forward for immediate adoption. It is obviously unnecessary to traverse the same ground twice. The same point should be kept in mind in connexion with those other problems of a medical character, i.e., dental benefit, maternity services and medical benefit for dependants, which are discussed in this Chapter in general terms and in Chapter XII in their more immediately practical aspects.

SECTION B.—THE ADDITIONAL TREATMENT BENEFITS.

76. From medical benefit we pass naturally to the various ancillary services which are or may be provided under the additional benefit schemes of the Insurance Act. Under additional benefit schemes (putting aside for our present purpose increases in the rates of cash benefit) provision may be made for in-patient treatment in hospitals (which includes nursing homes) dental treatment, ophthalmic treatment, convalescent home treatment, nursing and the supply of medical and surgical appliances other than those provided as part of medical benefit.

The General Arrangements.

77. Before we proceed to the details of these benefits it may be well to describe briefly the general arrangements under which they are provided. It is important in the first place to observe that at the present time there are two groups of additional benefit schemes in operation. One group is consequential upon the first valuation of all societies and branches made as at the end of the year 1918. The second group follows on the valuation of some societies and branches made as at the end of the year 1922. The schemes of the former group expire in July,

1926, when they will be replaced by new schemes operating generally until July, 1931. The schemes of the latter group came into force in July, 1925, and will expire in July, 1930. Thus, at the moment there are two sets of schemes in operation, covering different periods, and the terms of the two groups of schemes and the conditions enunciated in their schedules relating to the treatment benefits are not strictly comparable. In the later schemes efforts have been made to remove certain difficulties, and to avoid certain undesirable features which presented themselves in the actual working of the schemes. The details and figures hereinafter referred to are those applicable for the most part to the schemes as in operation in the year 1924. A scheme of additional benefits is contingent on the realisation of a disposable surplus by an Approved Society at one of the periodic valuations of assets and liabilities conducted by the Government valuers. A society which finds itself in this position may frame a scheme of additional benefits to be provided out of the surplus and submit it to the Department for approval. The schemes are applicable to all members of the society of five years standing and are current generally for a period of five years. So far as the scheme provides for an increase in the normal cash benefits, it is administered by the Approved Society as part of its normal work. In the case of those schemes which aim at providing treatment for the members, the arrangements for making payment in respect of the provision of the services covered by the scheme are made by the society either directly or through the agency of some institution or organisation. The member makes his application to the society, and receives his document of title stating the amount which the society will pay in respect of the particular service required.

78. It is important to observe that the additional benefits referred to consist not in the provision of treatment, services or appliances but in payment of the whole or part of their cost, as is indicated in the statutory description of the benefits. Subsection 5 of Section 75 of the Act provides, that "Additional benefits shall be administered by the society or branch . . except that where the benefits are in the nature of medical benefit, they shall be administered by and through the Insurance Committee." Though the construction to be put upon the words "where the benefits are in the nature of medical benefit" is not free from difficulty, the Departmental view, taken under legal advice, has been that any additional benefit which involves mere payment of money is not an additional benefit in the nature of medical benefit, notwithstanding that the money may go to secure service of a medical nature.

79. Whilst expressing no opinion on this point we think that it is highly desirable that the organisation of services which are

akin to medical benefit should be entrusted as far as possible to the bodies which are responsible for the administration of that benefit.

Criticism of the Additional Benefit System.

80. Many of the criticisms made on the provision of treatment benefits as additional benefits under the Act are directed to the fundamental characteristics of the system under which insured persons are grouped in Approved Societies. That subject is dealt with later in Chapters VIII and IX. Other criticisms are expressed on the following grounds.

81. These benefits are not given by all Societies, and even among the societies giving them there is it is stated not merely no uniformity in the additional benefits given, but there is also a wide and undesirable variety in the treatment, services and appliances included, and in the arrangements for part payment by the recipients. In other words, there is neither unformity in the selection of benefits nor in the content of the same benefit as given by different societies with the result, it is said, that there is widespread confusion in the minds of the members as to what precisely their rights are. Further, we are told that the arrangements made between societies and professional bodies are wanting in authority and uniformity, and in some cases are accompanied by undesirable conditions.

Here we need only point out that the promotion of an additional benefit to the rank of a normal benefit would remove many of these features since in that event its administration, as in the case of medical benefit, would be placed in the hands of the Insurance Committees or their successors.

We will now take the various additional benefits which are in intention of a medical nature and consider for each its present method of operation.

Dental Benefit.

82. For dental treatment as an additional benefit about £332,000 (including unspent balances carried forward from previous years) was available in England alone in the year 1924 and nearly the whole of this amount was spent in that year. In some Societies the benefit included extractions and fillings but not dentures, in others the position was reversed. There was also great divergence in the proportions of the cost borne by the Society and the member respectively. Some Societies paid the whole cost, other half, others again even less. A very wide latitude was allowed under the first schemes to Societies in the arrangements made regarding the scope of the benefit, the scale of charges, the proportion payable and the agreements with selected groups of dentists.

83. The evidence we have received from Societies shows that this is a very popular benefit, and it has been urged on us from many quarters that it should be made a normal benefit available for all insured persons on uniform terms. The Hearts of Oak Benefit Society state that, although they did not originally include dental treatment as one of their additional benefits, it was found necessary at a later date to diminish the additional cash benefits in order to meet the demands of the members for dental assistance (App. IV, 256). The Ancient Order of Foresters submit that " the provision of dental benefit, probably more than the provision of any other treatment benefit, would have the effect of conserving benefit funds so far as the drain due to sickness and disablement benefits is concerned " (App. V, 49). The National Conference of Industrial Assurance Approved Societies accept the view that it is desirable that a measure of dental treatment should be available to all members of Approved Societies, and make proposals for increasing the Central Fund so as to enable all Societies to make this provision (App. VI, 22). The Joint Committee of Approved Societies remark that " the only treatment benefit which would seem to justify an effort to secure it upon a national basis is probably dental benefit " (App. XIV, 28). The National Conference of Friendly Societies state that " there is a general desire throughout the Societies associated with the Conference that at the earliest date dental benefit should be made one of the normal benefits under the National Insurance Act with a possible restriction of the cost of full dentures to fifty per cent " (App. XXVI, 16). The United Women's Insurance Society have submitted to us some interesting figures and diagrams to illustrate the effect on the benefit fund of an adequate provision of dental treatment over a period of years (App. XXIV, 22-51), and urge that " dental benefit should take its proper place as part of an all-embracing medical service."

84. We have received professional evidence on this subject from the British Dental Association (App. XIX), the British Society of Dental Surgeons (App. XX), the Public Dental Service Association of Great Britain (App. XXII), the Incorporated Dental Society (App. XXVIII), the Ivory Cross (App. LXVIII), and the East of Scotland Dentists' Panel (App. LXXVII) as well as from the British Medical Association (App. XLVII). Finally, the official view is that the provision of dental treatment as a statutory benefit is most desirable if the money can be found. An official witness stated that " something like three-quarters of the industrial population, probably, are suffering from dental defects of one sort or another, and I think the experience of those Societies that have provided dental treatment as an additional benefit does give ground for hoping that systematic dental treatment would lead ultimately to a reduction of sickness benefit claims . . . ." (*Brock*, Q. 23,914). The general effect of this evidence is to emphasise the value

to health of timely, continued and effective dental treatment, the need for making the benefit generally available on uniform lines, and the adequacy of the number of qualified dentists to deal with the whole insured population. Considerable divergence of view exists regarding the possible methods of organising the service and also regarding the scope of the benefit in the immediate future, when heavy arrears of work would have to be overtaken and while financial conditions remain adverse. But the evidence as a whole leaves no doubt in our minds that any system of public medical services cannot be regarded as complete until it includes the provision of adequate dental treatment in a generally available form.

85. The British Medical Association admit that dental treatment should be an exception to the general principle urged by them, that any form of specialist treatment should be available only on the recommendation of the general practitioner (App. XLVII, 22-23; Q. 15,003-15,005, 15,109-15,111). We think this is sound in view of the more stringest qualifications now required for the dental profession and the character of dental trouble itself. At the same time, it in no way debars the general practitioner from considering dental defects in their relation to the general health of his patients.

86. The wider and more uniform provision of this benefit has, as we have said, been pressed upon us from many quarters. We have accordingly felt obliged to examine very closely its claims to be made a statutory benefit available to all insured persons in the same way that medical benefit is. The discussion of this question will be found in Chapter XII where it takes its appropriate place in the examination of the order of priority of certain proposals in themselves desirable in greater or less degree.

87. In closing this review of the evidence on the dental service we may refer to an important change made in the arrangements in July, 1925. Sir Walter Kinnear in reply to Q. 23,915 said : " Under the additional benefit schemes for dentistry at the present moment the insured person has a right to go to any dentist he chooses who is willing to do the service on the scale of fees agreed with the Societies generally. We do not allow Societies to select particular dentists. There is free choice of dentist. That is a development which has taken place during this year of course." He added (Q. 23,916) " I think the scheme is very much better than the one that was in vogue at the early part of this year."

Ophthalmic Benefit.

88. The official evidence indicates that next to dental treatment ophthalmic benefit is most in demand. (Ministry of Health App. I.B, 212.) For the year 1924 in England alone nearly £82,000 was available for it and of this sum about 37 per cent. or

£30,000 was spent in the year. It is not a costly benefit, the average charge per case being, we are told, about 15*s*. While there is a general consensus of opinion as to its value we have encountered, especially in the professional evidence, a strong conflict of opinion as to the method by which it should be provided. The British Medical Association (App. XLVII, App. C; Q. 15,006, 15,116-15,117, 15,145-15,154), the Council of British Ophthalmologists (App. LXIII, 2-3; Q. 17,777-17,778) and the Ophthalmic Benefit Committee (App. LXIV, 3-7; Q. 17,940 and 17,955) insist that in any case of ocular disorder or visual defect the benefit should only be available on the recommendation of a medical man basing their contention on the intimate connexion between the state of the eye and the general health of the body. They submit that the training of the general practitioner fits him to determine whether this recommendation should be made, and that for the purpose of dealing with any cases requiring special advice or treatment there is a sufficiently large number of medical men with training or experience in ophthalmology adequately covering the whole country. On the other hand the Institute of Ophthalmic Opticians (App. LX, 14-21; Q. 17,491-17,495, 17,506-17,507, 17,510), the Joint Council of Qualified Opticians (App. LXI, 27-32; Q. 17,628, 17,677-17,689, 17,694-17,697) and the British Optical Association (App. LXII; Q. 17,717 and 17,723) have urged that direct access to the optician should be allowed as in the case of the dentist, and have supported their argument by drawing attention to the training now required by these organisations and by citing the evidence of medical men. They also contend that " the medical practitioner's knowledge of optics is not so thorough as that of the optician " (J.C.Q.O., Q. 17,660), and while admitting the superior skill of the ophthalmic surgeon state that the number of such surgeons would be inadequate for coping with the work. We feel that this is a very contentious matter, on which it is difficult for laymen to pass judgment. But we understand that the Ministry of Health, acting on the advice of their medical advisers, have taken the view that the medical practitioner must intervene and in this conclusion we think we must concur. For a full statement of the views of the Ministry of Health on this difficult problem we refer to the reply by Dr. Smith Whitaker to Q. 23,956.

89. We are also informed that it has been clearly laid down by the Ministry and accepted by the medical profession that any work which might be involved in recommending a case as proper for the receipt of this benefit is included within the scope of the obligation already imposed on insurance practitioners towards the insured persons on their lists, and that consequently no question of any increased cost to the insured person obtaining the recommendation can arise (*Ministry of Health*, App. I, C, 67). Where such a recommendation has been granted or forwarded to the approved society, it is for that body to decide what steps shall be

taken to give effect to it. If the insurance practitioner advises a further medical examination of the patient's eyes the proper course is for the latter to consult a medical practitioner with special experience of ophthalmic work, who would diagnose the defect and provide such treatment as might be required. This would in the great majority of cases take the form of the testing of sight and prescription of the necessary glasses. It was claimed by witnesses representing various bodies of opticians that this work was within the competence of a qualified optician ; and we are prepared to admit that where no doubt can exist that the defect is merely an error of refraction the task of prescribing the requisite glasses should not be beyond the skill of an optician who has undergone the course of training and passed the examination required by certain of the opticians' organisations which gave evidence before us.

90. In this connexion, however, two difficulties arise. In the first place, in contrast with the position in medical practice and dentistry, there is not in this country any State registration of opticians and it is open to anyone to test sight and supply spectacles, however, unfit he may be to undertake the work. Secondly, in a proportion of cases, which may be no higher than 5 per cent., eye trouble may be due to some cause other than a mere error of refraction and may be a symptom of serious disease, and it is essentially a task for the qualified medical practitioner to differentiate between cases of this kind and cases of mere refractive error. It was admitted, even by medical witnesses who appeared before us to support the case of the opticians, that, other things being equal, it would be preferable, for the purpose of testing eyesight, to have recourse to a properly qualified eye-specialist rather than to the most highly qualified optician (*Joint Council of Qualified Opticians*, Q. 17,660). It is true that there has hitherto been a shortage of medical practitioners specially qualified in ophthalmic work and this, no doubt, has contributed to the result that the testing of eye-sight has very largely fallen into the hands of opticians. We are informed, however, that the British Medical Association has compiled a list of approximately 600 doctors in all parts of the country who possess special ophthalmic experience and who are willing to undertake this work for insured persons at a moderate fee. It is not within our province to consider the arguments for or against the prohibition of the testing of eye-sight by persons other than medical practitioners. But as to the provision to be made for insured persons as part of the Health Insurance Scheme, we consider that a satisfactory solution could be found in connexion with a proposal which we make in Chapter X directed to the provision of a specialist medical service as part of medical benefit. Such a specialist service would include ophthalmic specialists whose services would be at the disposal of insured persons requiring them, and the

function of the optician would thus in the case of insured persons, be limited to the making-up of the spectacles prescribed by the eye-specialist.

91. We may perhaps be allowed here to make one observation, even if it relate to a matter somewhat beyond our legitimate frontiers. In the case of midwifery and dentistry, we have recently seen the State compelled to make arrangements for limiting the practice of these professions to those possessing the requisite professional qualifications. In each case it has been necessary to provide for the inclusion in the Register at the outset of most, or of all, of those previously in practice, whether qualified or not. Such a situation, even if inevitable, may lead to not a little friction and professional unhappiness in the transitional period. The larger the volume of unqualified practice, the greater will be the difficulty of establishing matters on a satisfactory basis, and if in the case of any calling within the range of medical services it may ultimately be necessary in the public interest to prescribe the conditions of entry, much may be gained by taking the necessary step while the problem is still easily manageable. While expressing no opinion on the question, it is perhaps a matter for consideration whether problems similar to those which led to the Registration of Midwives and to the Dentists Act of 1921 are not in process of being engendered elsewhere. Two such examples which occur to us are those of the opticians and the masseurs.

Hospitals and Convalescent Homes.

92. Nearly £538,000 was available in England in 1924 for this benefit, but only about 40 per cent., or £220,000, was expended in the period. Payments under this heading do not necessarily relate to specific applications by members, but may, in schemes consequent upon the first valuation, take the form of an annual payment to a hospital or home for the purpose of securing treatment of members therein. The benefit is limited to in-patients. The payment of travelling expenses, in whole or in part, is included within its scope. A common method of administration is for the hospitals to send periodically to the societies concerned lists and particulars of members who have received treatment and for the societies to pay the hospitals at an agreed rate, frequently 25*s.* or 30*s.* a week per patient.

93. We have received evidence as to these arrangements from the British Hospitals Association (App. LVII), the Sheffield Joint Hospitals Council (App. LVIII), and the Middlesex Hospital (App. LIX). Attention is directed to the fact that the treatment of insured persons by insurance practitioners is incomplete because it is not satisfactorily linked up with provision for treatment in hospitals. It is represented that while any payment made by societies with additional benefit schemes

is welcomed, nevertheless owing to various causes no payment is made from insurance funds in respect of a large proportion of those insured persons who receive treatment. Even in the case of those for whom insurance payment is made, the amount contributed is only a part of the average cost per occupied bed per week. No payment at all is made in respect of the general out-patient work which the witnesses urge " is of great economic value not only to the State as a whole but also to Approved Societies in particular, by enabling members to return to their work more quickly after illness or accident " (British Hospitals Association, App. LVII, 7). In connexion with this last point we examined witnesses to ascertain whether insurance practitioners were evading their proper work by sending their patients unnecessarily to the out-patient departments of the hospitals. But we are assured that this is not so to any extent, and that " the tendency is for the out-patient department to become more and more consultative, and patients appreciate the value of the benefit of treatment by the consulting staff of the hospitals " (British Hospitals Association, App. LVII, 10). We are told that, whereas in the past patients attended at the out-patient department almost entirely of their own volition, the number coming now on the advice of their medical attendants is about 50 per cent. of the total.

94. The contention of the hospitals is, therefore, for a fuller measure of financial assistance in respect of all insured persons using the hospitals in any way. At the same time they are opposed to any encroachment on their voluntary status, and the British Hospitals Association suggest that "there should be no contract to treat, but . . . that the important role filled by the voluntary hospitals in supplementing the work of the panel practitioners and in furnishing the additional services . . . should be recognised by practical assistance from insurance funds " (App. LVII, 14).

95. The figures of costs submitted by the Sheffield Joint Hospitals Council in App. LVIII are of interest. It appears that, in 1923, in respect of three general hospitals in Sheffield, the total cost of providing services to patients (3,221 in-patients and 15,269 out-patients) who were insured persons was £28,870, while the total amount received from insurance funds was only £4,300. In considering these figures it must, however, be borne in mind that, had there been no Insurance Scheme, the hospitals would still have borne the cost and would have been without the substantial relief which the Insurance Funds have brought Further, the insured persons, like other citizens, make voluntary contributions to the funds of the hospitals through subscriptions, collections, club arrangements and the like; and they receive from the hospitals no preferential treatment over the rest of the population.

The British Medical Association have submitted in Appendix XLVII a full statement of their policy with regard to hospitals. Their attitude, so far as finance is concerned, may be gathered from the following quotation :—

> " The Association recognises a dual policy as regards the voluntary hospitals; (*a*) that the purely charitable side should be continued wherein the whole cost of the maintenance of indigent patients is met by the gratuitous contributions received by the hospital, and on whose behalf the services of the honorary medical staffs are given gratuitously; (*b*) that other patients who are not indigent may be received for treatment at voluntary hospitals when they cannot pay for, or cannot obtain, adequate treatment elsewhere, and that, for them, payment should be received by the hospital either from the patients themselves or, on their behalf, from the authority or body referring them to the hospital, and that, on account of their treatment, some method of remuneration of the honorary medical staff should be arranged." (App. XLVII, Sub-App. D, paragraph E, 3.)

The implication is that, in respect of insured persons, payment, including an amount for the remuneration of the honorary medical staff, should be made by the societies to the hospitals

On the question of the relationship of the out-patient department to the general practitioner the Association enunciate the general principle that the primary object of the out-patient department should be for consultation, and that only such treatment should be given therein as cannot consistently with the best interests of the patients be properly undertaken by a general practitioner of ordinary professional competence and skill. (App. XLVII, Sub-App. D, paragraph 25.)

96. The National Association of Trade Union Approved Societies have submitted in paragraphs 138-139 of App. XCII, their policy in regard to hospitals. They contemplate a complete system of treatment centres, local or cottage hospitals, county hospitals and national hospitals under public control and supported by public funds, but " would give voluntary hospitals the option of being taken over by the Health Authorities entirely or of receiving grants from public funds conditional on efficiency." " The Local Health Authority should be represented on the Boards of Management, and though remaining on an entirely voluntary basis, such hospitals should work in co-operation with the public hospital."

Provision of Nurses.

97. The amount available in 1924 for this additional benefit was in England about £152,000, of which, however, only 4 per cent., or about £6,000, was spent in the year. Difficulties of administration have been encountered, we are told, owing to the

members of any one society being widely scattered throughout the country, to drawbacks of organisation and " to the general paucity of demand under present conditions for such services " (Ministry of Health, App. I, B, 210). The usual financial arrangement between the Societies and the Nursing Organisations provides for payment being made at the rate of 1*s.* 4*d.* per visit, of which the Society pays 1*s.* and the member 4*d.* We have received professional evidence from the Queen Victoria's Jubilee Institute for Nurses (App. LXXII) and the College of Nursing (App. LXXIII), the former being engaged in the practical work of providing nurses throughout the country, and the latter in the promotion of the better education and training of nurses and in watching their professional interests.

98. The Queen Victoria's Jubilee Institute points out that " there is already in existence a national service which can and does provide skilled nursing for all kinds of illnesses at an economical rate and under proper safeguards—a service which, though not completely covering the country, is capable of being made to do so," and urges " that nursing should be provided for all insured persons, and that in doing so advantage should be taken of the existing organisations." (App. LXXII, 16.) The rates of payment arranged between the Institute and numerous Approved Societies is 1*s.* 4*d.* a visit for the first 30 visits, and thereafter not more than 5*s.* a week, and 5*s.* for a nurse's attendance at an operation. In some cases the Society pays the full amount, in others it pays 1*s.* and leaves the Nursing Association to collect the balance from the insured person.

99. The witnesses who appeared on behalf of the College of Nursing also suggested the need for a wide extension of the nursing service of insured persons in place of the present additional benefit arrangements, which they characterise as " inequitable, fragmentary and wholly inadequate." (App. LXXIII, 9.) In fact, they " urge the provision of a statutory nursing benefit complemental to medical benefit " (App. LXXIII, 3 and 15), and suggest that a sum of 1*s.* per insured person per annum would go far to provide the requisite finance for this complete service. (App. LXXIII, 14.)

100. The Ministry of Health representative makes the following comments:—" The ground is already to a considerable extent covered by the District Nursing Associations, particularly in urban areas. . . . . By undertaking the provision (i.e., as an additional benefit) you are not adding very much really to what the patient can get or what they would otherwise get." (*Smith Whitaker*, Q. 23,968.) " If you were proposing to provide a nursing service for the whole community you might take over the whole of their (the Nursing Associations') organisation and develop it, but if you are going to provide nursing for a section of the community . . . you cannot do it better than by

making arrangements with the District Nursing Associations who are already doing the work for so many other people." (*Smith Whitaker*, Q. 23,971).

Medical and Surgical Appliances.

101. The provision of medical and surgical appliances is, we are told, a fairly widely adopted benefit, for which in the period from July, 1921, to December, 1922, the sum of £69,804 was available in England, but out of which only £3,348 was spent, or just over 4½ per cent. Appliance means a medical or surgical appliance other than a dental or optical appliance or those other appliances already prescribed as part of medical benefit by the Regulations. It has been held to cover such diverse articles as a motor ambulance, a bath chair, surgical boots, artificial limbs, trusses and hot-water bottles. For the most part it is not an expensive benefit, though the average cost per case in some societies has been between 30*s*. and 40*s*. Sometimes the whole cost is paid by the Society; sometimes only half above a fixed maximum, for example, £4.

Other Suggested Additional Benefits.

102. We understand that suggestions have been made to the Department from time to time advocating the inclusion of massage, electrical and radiant heat treatment, laboratory facilities, specialist treatment, and spa treatment, in the list of additional benefits (Ministry of Health, App. I, B. 219). We ourselves have received strong representations from witnesses as to the first and last (See Apps. LXVII and XCVI). The Ministry of Health representative, in particular stated—"There can be no doubt as to the value of massage and electrical treatment, particularly for cases of after effects of injuries and rheumatic conditions by which a large amount of prolonged incapacity for work is produced. . . . Such a service might be provided as an additional benefit . . . but it would not be practicable to provide a satisfactory service unless you had security for effective organisation. . . . Such a service would be more economically and efficiently provided as a part of statutory medical benefit." (*Smith Whitaker*, Q. 23,973.)

Tuberculosis.

103. Having concluded our review of the additional benefits of a medical nature we may now pass on to refer briefly to the treatment of tuberculosis. This has been the subject of representations to us from the London County Council (App. LXXXIV), the Joint Tuberculosis Council (App. XCIII) and the Cambridgeshire Tuberculosis After-Care Association (App LXXXIII). Institutional treatment of Tuberculosis was removed from the Insurance Scheme in 1921 and entrusted to

the Public Health Authorities, by whom it has been greatly developed and made available for the whole community. Domiciliary treatment, however, remained as part of the service which the insurance practitioner contracted with the Insurance Committee to give to his insured patients. In this Chapter we need do no more than point out that the removal of the institutional treatment of tuberculosis marked a distinct change in the conception of the responsibility of the State in this matter as in place of provision for a restricted class, who in part paid by insurance contributions for the service provided, there was substituted a provision available for the whole population and supported entirely by rates and taxes. We may quote the following reply to a question we put to the Ministry of Health representative on this question. "An effective scheme for the treatment of tuberculosis cannot be confined to one section of the community, and the placing of the responsibility for the treatment of all sections upon one local authority has had the substantial advantages of (1) preventing local administrative overlapping, (2) simplifying supervision by the Central Department, and (3) enabling due attention to be given in the further development of local tuberculosis schemes, to the needs of other sections of the community, besides the insured, and especially children. Even from the point of view of insured persons this is an advantage as their dependants constitute the larger part of the non-insured section of the community." (*Maclachlan*, Q. 24,092.)

SECTION C.—THE MEDICAL SIDE OF MATERNITY BENEFIT.

104. No survey of the health services under the Insurance Act would be complete if it omitted to take account of maternity benefit. It is true that this is a cash benefit administered directly by the Approved Societies, and that it differs from the additional treatment benefits in that there is no control of the application of the money given. Yet the money does in large part go to pay for the services of doctor and midwife and the underlying purpose of the benefit is to promote the health of mother and child at the critical period of pregnancy and childbirth. Having regard to the great importance of skilled advice and treatment at that time, we feel confident that any development of this benefit will be in the direction of an increase of the service element provided under appropriate conditions of control. Accordingly we proceed to a consideration of the maternity provision and the evidence that we have received in this connexion.

Evidence as to Maternity Benefit.

105. Taking the professional evidence first, we find that the British Medical Association in this as in the general problems

recommends medical unification of the services. "Provision in connexion with maternity and infant welfare" should be made "an integral part of the Insurance Scheme or brought into proper relation thereto" (App. XLVII 19-20). In paragraph 29 of the same Appendix they point out that "attendance in connexion with confinement is expressly excluded from medical benefit, and such public provision as insured women and the wives of insured men can avail themselves of is under other auspices and is not complete in character." They recommend that in addition to a cash payment there should be suitable ante-natal examination and supervision, attendance at confinement and during the puerperal period by a midwife or doctor as the case requires, consultant and specialist service available for difficult cases, provision for institutional treatment where necessary (App. XLVII, 29, 30; Q 15,118-15,129).

106. The Society of Medical Officers of Health who, as representing the medical advisers of the bodies responsible for the work of the Maternity and Child Welfare Centres, speak with special authority in this matter, say that "the maternity and child welfare schemes have involved local authorities in large expenditure frequently greatly exceeding the total amount of maternity benefit paid in their district." They point out that "These schemes are of the same essential nature as maternity benefit and the only practical method by which this latter benefit can be administered in the interests of the mother and child is by requiring local authorities to administer it through their statutory Maternity and Child Welfare Committees." After reciting the need for the same elements of medical attention as those recommended by the British Medical Association they go on to say that "maternity benefit even in money value should vary according to the necessity of the mother and the medical character of the case" (App. LVI, 9). They conclude with the following recommendations:—

> "Maternity benefit, whether in its present, or in an extended form, should cease to be administered by Approved Societies and be administered both in money and kind by local authorities; which, in their turn, should be made definitely responsible for providing medical attention. The attendance upon maternity cases should not be an obligation upon a panel practitioner." (App. LVI, 14 (10); Q. 16,992.)
>
> "Maternity benefit should provide for all necessary medical attendance in pregnancy and maternity, and medical benefit should be understood to be exclusive of such medical attendance." (App. LVI, 14 (11).)

107. Very interesting evidence on this subject was given by the late Mr. Benjamin Broadbent, who devoted so much of his life to the furtherance of public health work, especially in its bearing on the welfare of mothers and children. He regarded the

maternity benefit of the Insurance Scheme as " a great opportunity missed." " The real purpose which Parliament had in view was undoubtedly to make childbirth safer alike to mother and child. This purpose cannot be fulfilled merely by a grant of money " (App. XXIII, 3; Q. 10,140-10,146). He considered that though the benefit is a real help and is properly utilised in many cases, its cash character and limited scope condemn it and its administration by Approved Societies as unsatisfactory (App. XXIII, 4-9). He held the view that the whole administration of the maternity benefit should be transferred to the Public Health Authority and incorporated with the work of the Maternity and Child Welfare Centres (App. XXIII, 10-12; Q. 10,061-10,066, 10,091).

108. The Incorporated Midwives' Institute (App. LXXIV), while considering that " maternity benefit is a useful institution and should be maintained," are of opinion that " it should not only mean a cash benefit but also, when needed, a treatment benefit directed specially to the condition of pregnancy, that sick pay for four weeks after confinement should be given, and that the benefit should include ante-natal treatment." The Scottish Midwives Association (App. LXXV) support these views and add that " an additional maternity nursing benefit " should be made available under certain conditions. On the fundamental question of the transfer of maternity benefit to the Local Health Authority we were told that these bodies had not considered the matter (Q. 19,781), but in answer to Q. 19,790 a bias towards some form of unification appeared.

109. Evidence from Approved Societies and their representative bodies was generally to the effect that the fees of doctor or midwife tended to absorb the whole benefit and leave nothing over for comforts, extra nourishment and other requirements arising at the time of confinement and that these fees had been increased substantially as the larger benefits (increased for cost of living and by additional benefits) had become available (see e.g., Hearts of Oak Benefit Society, Q. 3490-3491, 3529; Independent Order of Rechabites, App. VIII, 6, Q. 6110-6111; Scottish Co-operative Friendly Society, App. LXXVIII, 2, Q. 20,326-20,327; National Federation of Rural Approved Societies, App. XXIX, 14). Other witnesses advocated a proposal that the fees for doctor or midwife should be made a statutory charge on the general medical fund so as to prevent this absorption of the whole benefit (see Association of Approved Societies, App. XLV, 11-12; Scottish Co-operative Friendly Society, App. LXXVIII, 2, Q. 20,328-20,330). The Standing Committee of Scottish Insured Women recommend that definite provision should be made for the payment of sickness benefit during the four weeks prior to confinement (App. XLVI, 6).

110. The National Association of Trade Union Approved Societies recommend that medical benefit should include treat-

ment and attendance before, during and after confinement (App. XCII, 101), that " benefit sufficient for the full and healthy maintenance of an insured woman and her child should take the place of maternity benefit," " that these provisions should be administered through Local Health Committees " (App. XCII, 130-131). They also draw attention to the fact that although the general death rate has been reduced by one-third, no corresponding reduction has occurred in the rate of maternal mortality, despite the expenditure of £1,500,000 a year on maternity benefit, and they suggest that in the prevention of this evil a solution may be found to the problem of excessive expenditure on disablement benefit in respect of women (Q. 22,057). The Standing Joint Committee of Industrial Women's Organisations make recommendations on the lines of the Washington Convention and urge the expansion of the work of the maternity and child welfare centres (App. C, 17-27). The Sons of Temperance Friendly Society say :—

> " Opinion has been obtained from the Grand Divisions (N.H.I. units) of this Society on the question of this benefit, and it is found that there is general dissatisfaction with the present method, which, instead of providing definitely, in money or in kind, for the direct and special benefit of the mother—and, incidentally, the child—as was intended by the original Act, there is in many cases a demand made upon the financial resources (often slender enough) of the home, beyond the cash value of the benefit. Instances of medical fees up to five guineas, and midwifery fees up to two guineas, have been cited.
>
> " This Society suggests that maternity benefit should be made completely statutory, and should consist of (*a*) a definite cash payment to the woman confined; (*b*) a fee for all needful medical or midwifery services, chargeable to the funds of the Approved Society " (App. LXXXIX, 69-70).

111. The National Federation of Insurance Committees, recommending a complete medical service for insured persons and their dependants, say that this should include maternity services which would be additional to any cash payment that might be available (App. XXXVI, 223, 234). The National Association for the Prevention of Infant Mortality make the following recommendations :—

> " The Maternity Service as a part of maternity benefit should provide, in addition to a cash benefit :—
>
> (1) Ante-natal examination during pregnancy, by a registered medical practitioner, with any necessary report.
>
> (2) Adequate professional attendance during pregnancy, normal labour and the puerperium.

(3) Provision of medical services if and when called in by a registered midwife who has been engaged to attend the confinement.

(4) Consultant service.

(5) Institutional treatment.

The payment of the cash benefit should be distributed over several weeks before and after the confinement and not be paid over in one lump sum. The Association are of opinion that the Medical and Maternity Benefits Services should be regarded as a health service and be grouped with other such services for administrative purposes; that is, under the Public Health Authority" (App. CXXIV, 9 and 10).

112. The Ministry of Health representative, in answer to questions on the subject, gave the following reply: "This is a matter that has been discussed several times with the medical profession in 1919 and since, and I think that the general feeling is that, if the requisite financial arrangements could be made, it would be very desirable to end the present system under which you have the general practitioner responsible for treatment before labour but having no responsibility during labour, the midwife, under an entirely independent authority, giving attendance in labour and calling in a practitioner to attend in labour, if necessary, who would be paid by the local authority; then you have the maternity and ante-natal centre giving assistance in the early stages. There is a great deal of overlapping and probably a good deal of waste, and it would be most desirable, if it could be arranged, to have a scheme that brought the family doctor, the midwife, the specialist, if necessary, and all the services that are available at the maternity centre, under a common scheme and a common control, so that they each played their proper part and were brought into proper relation with each other, helping one another instead of acting at a distance as they do now." (*Smith Whitaker*, Q. 23,896.)

113. Closing this summary of the evidence on this important question, we note that the National Conference of Friendly Societies, to whose advocacy of a radically reformed Health Service we have elsewhere referred, include all the maternity work of the various agencies as part of the material to be incorporated in their proposed unified scheme (App. XXVI, 30-41).

Separation of Money Provision and Treatment.

114. On a review of all the evidence we have heard we have come to the conclusion that the present elements of maternity benefit should be ultimately dissociated from each other, that is to say, any cash payment made on confinement should be separated from the medical, nursing and institutional services of all kinds provided in connexion with the condition of pregnancy. The former should, we think, continue to be

administered by the Approved Societies. The latter would be provided as an integral part of the medical service and would be administered by the appropriate local authority. The general practitioner, the midwife, the nurse, the specialist and the institution would all take their respective parts in the scheme of extended medical services.

SECTION D.—INTER-RELATIONS OF THE HEALTH SERVICES.

115. To complete our review of the health services we naturally pass on to consider the public medical services outside the Insurance Scheme, and this leads inevitably to the extremely important problem of co-ordination of the health services generally. We have already, in Chapter IV, given a brief description of these activities of the Central Government and the various Local Authorities. We may also refer to the detailed accounts supplied by the Ministry of Health (App. CIV), the Scottish Board of Health (App. CV), the Board of Education (App. CIX) and Sir Thomas Legge (App. XLII). Naturally we have not heard on these topics such a range and variety of evidence as we have received on the Insurance medical service. But we have been sufficiently informed of the nature of the arrangements supervised by these Departments, and many witnesses, e.g., the Society of Medical Officers of Health (App. LVI) have directed our attention to these State activities and have emphasised their intimate relation to the problem of the future of public health work in the broadest significance of that term. Here, again, as in the case of medical benefit, we have been impressed by the social value of these various activities, the great advances that have been made *pari passu* with the development of the Insurance Scheme, and the possibilities of expansion that are latent in these schemes if the necessary public funds could be made available. Most important of all, we have been impressed by the feeling that, in any further developments, the need for close co-ordination between the health work within the Insurance Scheme and that outside it, must be continually kept in view both in the administration and in the essentials of professional work.

116. We will refer, first, to the reports of the Consultative Councils of the Ministry of Health and of the Scottish Board of Health, made in 1920. In these reports the greatest emphasis is laid upon local co-ordination of all the health services. The former approach the subject on a theoretical basis and describe what the organisation of a complete health service should be, quite apart from existing systems and commitments. The latter deal with the problem more in the practical sphere, and, taking things as they are in Scotland, indicate the desirable lines of progress. But in both the underlying principles are the same—

a carefully built-up service organised on a single local basis in which all varieties of preventive and curative work find their appropriate place. (For an outline of the substance of the English reports see Q. 24,170-24,172.)

The Professional Evidence.

117. From the evidence we have received from a wide variety of witnesses similar conclusions may be drawn. For example, the British Medical Association say: "It is essential, not only that the attention of all practitioners should be directed continually to the preventive aspects of their work, but that the existing machinery and medical officers of the Public Health Service should be brought into close and organic connexion with the Insurance Scheme." (App. XLVII, 3); and again: "It is desired to make all such benefits and services (i.e., pathological facilities, treatment for tuberculosis and venereal disease and for certain infective fevers, the treatment of certain conditions of children of school age, provision in connexion with maternity and infant welfare) an integral part of the Insurance Scheme or to bring them into proper relationship thereto" (App. XLVII, 20). The Society of Medical Officers of Health point out that their service, "primarily concerned in the preservation of health generally, has from the beginning recognised the impossibility of adequately discharging its function in dissociation from measures for the restoration of health to individuals." "It has become evident that the present system of National Health Insurance suffers great limitations in its possibility for promoting health, and that profound changes are required if the improvement in the health of the people is to continue to be aided and not impeded by it." "The scheme . . . is, to a great extent, isolated from the other schemes of the State in operation and doing essentially similar work . . . the relationship of such work to that done by local authorities should be of a most intimate nature." "Centrally it is true that the administrations are amalgamated in one Government Department, but such an amalgamation is of comparatively little value if the practical and detailed working of each in local areas is ill co-ordinated or impossible" (App. LVI, 1-4). "The need for some genuine co-ordination of all the medical agencies in every area has long been severely felt, and the intricate and costly nature of the provision necessary for the people constitutes an additional reason for a full co-operation of all the institutions and personnel taking part in this work." (App. LVI, 11; Q. 16,934-16,940, 16,972-16,974.)

The Lay Evidence.

118. These are professional opinions. From the lay side come similar recommendations. For example, Mr. Alban Gordon says in paragraphs 36-41 of Appendix XIII.—"The unification

of central control which took place when the Ministry of Health was established was unaccompanied by any corresponding unification or co-ordination of existing medical services locally . . . At every stage medical benefit overlaps with one or other of the large number of existing forms of medical service . . . and this duplication of effort between the Insurance Act and existing medical services is a grave source of weakness and expense." The National Conference of Friendly Societies, representing four million State insured members and a total voluntary membership of 7,400,000, has submitted to us the interesting and important conclusions contained in paragraphs 34 to 41 of Appendix XXVI from which we quote the following :—

> " Few will deny that it is highly wasteful and inefficient to allow six or more separate organisations for medical services (all paid for wholly or mainly out of public funds) to exist side by side, as they do to-day, with consequent overlapping, friction and duplication of expense.
>
> " This becomes all the more marked when it is remembered that for one-third of the entire population there is, in addition, a general practitioner service provided in the form of medical benefit under the Insurance Act.
>
> " Notwithstanding all these various medical services, there exists little or no provision for specialists' and consultants' services for the fifteen million insured persons, whilst for the twenty millions or so dependants of insured persons there is no general medical service except that of the Poor Law.
>
> " Owing to lack of means, it is impossible for the poorer classes to obtain the services of doctors on fee-paying terms, and for this reason it was deemed necessary to introduce a system of compulsory insurance to include free doctoring. It is submitted that the need is equally great to-day for similar provision for the remainder of the population below an income limit of, say, £250 a year, including the dependants of such persons, as well as those of insured persons.
>
> " If this were done by merely extending medical benefit on its present basis to dependants of insured persons, it would :
>
> > " (*a*) Greatly intensify the overlapping of services already referred to;
> >
> > " (*b*) Be extremely costly, because a large number of panel practitioners would be, in effect, working full-time on payment basis devised for part-time work;
> >
> > " (*c*) Leave out of the scheme at least one and a half millions of persons including not only the destitute, but a number of non-insured persons, such as hawkers, small shop-keepers, &c.

> "It is, therefore, suggested that the best way of organising the provision of medical treatment is to merge *all* existing forms of public medical service (including medical benefit under the National Health Insurance Acts) into one National Medical Service, thereby creating one unified organisation for the prevention and cure of disease. Under this system, the service would be provided for all persons below a given income limit."

119. We naturally questioned the official witnesses of the Ministry of Health on this problem and received replies indicating generally that closer co-ordination was regarded as desirable. For example :—"Reference has already been made to the general arrangements which have been or may be made for co-ordinating the work of public health services with the Insurance Medical Service. Any effective arrangements for such co-ordination should tend to diminish disease and sickness." (*Maclachlan*, Q. 24,226.)

"As regards the Poor Law Service I understand that it is not considered that further progress in the direction of co-ordination with the Insurance Medical Service is likely so long as the present division of work between the various local authorities is maintained." (*Maclachlan*, Q. 24,027.)

"If provision in one area of two services providing identical assistance for different, although only slightly different classes of the population is regarded as overlapping, then it is present in a very substantial degree." (*Maclachlan*, Q. 24,037.)

"The Maternity and Child Welfare Service provides many forms of assistance which a slightly different class of woman may get from the Poor Law Service. The same would hold good I think as regards tuberculosis." (*Maclachlan*, Q. 24,038.)

"The present arrangements are not, however, regarded as permanent. The ideal to be aimed at is a single Public Health Authority in each area, responsible for the whole of the public health services, but this can only be attained in connexion with a general reorganisation of local administrative areas and a consequent revision of the functions of the local authorities." (*Maclachlan*, Q. 24,155.)

"It cannot be said that there is any general or complete co-ordination between the medical work of Poor Law authorities and other health services." (*Francis*, Q. 24,165.)

"Is there any sound reason why the provision of medical attendance for sick persons who are destitute should be in the hands of a separate local authority?"—"I know of none." (*Francis*, Q. 24,166.)

"Would you agree that it would be a great advantage if the whole of the health services in any area, whether for the insured or uninsured, destitute or not destitute, were in the hands of the same authority? Would it be in accordance with the views

of the Ministry that in any reorganisation of the local administration of the Insurance Medical Service this end should be kept in view? ''—'' The answer to both parts of the question is yes.'' (*Maclachlan*, Q. 24,169.)

120. This large volume of representative evidence leads us to the general conclusions that whatever may be the changes which are made in the Insurance scheme in the near future, the trend of the development will be towards a unified health service, and that in determining future changes full account of this tendency should be taken.

SECTION E.—SOME GENERAL CONSIDERATIONS.

121. We do not feel that it is for us to explore in any detail the problems of the future to which this principle of unification must necessarily give rise if it is accepted. That there will be many and difficult questions so ensuing must be evident to all who look with any wide view at the diversity of services of a medical nature now provided or supervised by the State. Such problems as the nature of the services, the manner in which they should be inter-related, the range of persons for whom they shall be available, the financial arrangements by which they will be supported, the appropriate division of the work between the central and local authorities—all these are problems which confront the students of our social system and to which, we think, a solution must ultimately be found.

122. But though these matters cannot be dealt with at the moment, and are perhaps in any case beyond our Terms of Reference, we are glad that our proceedings have afforded the opportunity to many witnesses to state their views thereon. Such general expression given from a number of different points of view, e.g., that of the Medical Profession, that of the Approved Societies and Insurance Committees, that of persons so peculiarly interested in these developments as the Medical Officers of Health, that of independent observers and critics, cannot but be a valuable contribution to the consideration of these difficult problems and should be of assistance to those who at some future date will attempt their solution. We who approach these matters from the point of view of the medical benefit provided under the Insurance Scheme, need only consider one or two matters of somewhat more limited range.

Central and Local Co-ordination.

123. In the first place we may mention the question of co-ordination of effort in and between the Central Departments. On this point we have examined the official witnesses of the Ministry of Health which, as we have pointed out in Chapter IV,

already controls most of the health services. We have also considered the statement submitted by the Board of Education on the school medical services; and Sir Thomas Legge of the Home Office has described to us in considerable detail the medical services in the factories. We are told that co-ordination is effectively secured between Departments by consultation and other official machinery (see *Brock, Maclachlan and Francis*, Q. 24,025-24,196). Similarly, we are told that within the Ministry of Health itself the various branches are maintained in effective relationship (*Kinnear*, Q. 24,197-24,201). We are glad to be reassured on this point, but we would suggest that, as the various national schemes are advanced along the lines of their natural development, it will be essential to secure at each stage the utmost degree of co-ordination at the centre.

124. In the second place there emerges prominently the problem of the multiplicity of the local authorities whose work we have described in Chapter IV. Here again, approaching the question from within our Reference, we have to consider the future of the Insurance Committees, with their related bodies, the Local Medical Committees and the Panel Committees. A full account of the duties of these three groups of bodies is given in Appendix I, Section C, to our Minutes of Evidence. We will turn first to the Insurance Committees.

The Insurance Committees.

125. If, as we think, there is to be a concentration of local health functions in the hands of a single Authority, the powers and duties of the Insurance Committee would naturally pass to that Authority. We have come to the conclusion that a change in this direction may justifiably and conveniently be made in the immediate future, the functions of the Committees being transferred to the appropriate municipal and County Authorities. In view of the importance of this proposal we devote a large section of Chapter XII to its discussion and to a review of the evidence directed to the activities of the Insurance Committees. Here we need only say that though Insurance Committees and their staffs have done their work well, and at the outset some advantage undoubtedly resulted from the attention and energy which specially instituted bodies could devote to the launching of the new scheme, yet owing to a variety of causes, there is not now work of a quality or volume to justify the continued existence of this separate organisation. That, of course, is not the main argument from the point of view expressed in this Chapter. We would urge unification as the ultimate aim even if the work of Insurance Committees were in fact substantial. But it is not; and we are thus spared the necessity of advocating on one principle the disappearance of a system which justifies its existence on another.

The Local Medical and Panel Committees.

126. Passing now to the consideration of the Local Medical Committees and the Panel Committees, we would observe in the first place that these bodies have proved a valuable element in the medical side of the Insurance Scheme. The principle of having in each area a representative body of medical men, to whom professional questions are referred and by whom many of the administrative problems affecting the insurance practitioners are considered, has evidently been acceptable to both lay and professional opinion. It might be held that the same results would be obtained by the presence of elected or co-opted medical members on the local administrative bodies. But we think—and evidently the framers of the Scheme thought also—that something more than this was desirable; and that to secure the full co-operation of the Medical Profession, so necessary to the scheme of medical benefit, the independent position given by the two statutory and purely professional Committees was essential. It is true that in most cases the two Committees have the same personnel, and indeed we are told that the Ministry has in many areas recognised the Panel Committee as the Local Medical Committee. Yet each represents a distinct idea, the former the effective voice of the practitioners in contract with the Insurance Committees, the latter the combined experience and opinion of all types of medical men in the area whether "on the panel" or in the most exalted specialist practice. Under such an extension of medical benefit as we recommend in Chapter X and even more so in any larger developments of the future, the two Committees will necessarily tend to coalesce and become, if they are continued, the single expression of professional wisdom in the area. We do not doubt that they will be continued in any immediate developments, and equally we see in them the hint of a local professional committee working side by side with the single local health authority in all parts of the country.

Availability and Finance.

127. Much of the evidence we have received on the general subject with which we are now dealing has been directed towards two highly important problems, namely, the classes of persons for whom the public and insurance medical services should be available, and the manner in which the costs of such services should be met. At one extreme are those who would limit the services strictly to the necessitous and finance them from public funds, leaving the rest of the population to make their private arrangements. At the other are those who advocate the provision of a complete service for the whole population without distinction of class or means, the cost being defrayed entirely from Exchequer grants and local rates.

128. Between these extremes lie those who would retain the insurance principle as a means of raising part of the necessary funds and would weave it, in some way not very clearly defined, into the financial web. For example, the British Medical Association contemplate a line drawn horizontally across the structure of society. Above that line everything is to be left tc private effort, except those services which are of a public health character in the strictest sense. Below that line they would admit a comprehensive service embracing all medical elements and incorporating all the activities of the local authorities which stand at present apart from the insurance service. The service which would thus be limited so far as concerns those for whom it would be available, although in its content of the widest scope, would be financed from a combination of public and insurance funds. The principle governing the limits within which such a service would be available is enunciated in the following words : "The medical provision should be available for those persons, and only for those persons, who would be unable to obtain it without the help of an Insurance Scheme . . . the medical provision made for such persons should be, as far as possible, complete." (App. XLVII, 8; Q. 14,689-14,708, 14,806-14,817.) In other words, the witnesses who appeared on behalf of the British Medical Association, contemplate a unified and complete service resting in part on insurance funds which should, however, be restricted to the poorer classes of the community.

129. On the other hand, such a scheme would be broader than the present scheme of Health Insurance, as it would ignore the distinction between those employed under a contract of service, and those working on their own account who are at present outside the scope of the Acts. This scheme would, moreover, include the dependants of both these classes. We questioned the witnesses closely as to the income limit at which the line should be drawn, but did not receive any very definite suggestion on the point. They apparently contemplated something substantially higher than the present destitution test for the complete medical attention given by the Poor Law authorities, but lower than the present insurability limit for non-manual workers (£250 a year), with the further proviso that dependants should only be included if the person on whom they were dependent had an income substantially below that figure. The general effect of these proposals would be to exclude from the scheme instituted by the State a substantial number of the present insured class but to bring within the scheme a greater number than those so excluded, consisting of the dependants and of the various classes of persons of small means at present outside the existing insurance scheme. To this enlargement of the sphere of "contract practice," there appeared to be no objection on the part of the British Medical Association, assuming that a sufficiently low income limit should be conceded in defining those for whom

the health service should be available. They do not appear to have contemplated the possibility that in some areas the proportion of the population who would be embraced within the scheme under any income limit likely to be acceptable to the industrial classes, would be so large as to afford a strong argument on grounds of public economy for the replacement of the contract system by a whole-time salaried service.

130. The National Association of Trade Union Approved Societies appear to have accepted the insurance principle, and indeed, desire to extend it in several important respects (*see* App. XCII, paras. 102-104). The National Conference of Friendly Societies approve, as we have indicated above, a complete reorganisation of all health services on a public basis financed entirely from rates and taxes.

131. Mr. Alban Gordon makes the following statement :—

> " My own personal predilection would therefore be in favour of abandoning altogether any attempt to base a National Medical Service on insurance funds, to abolish medical benefit altogether, relieving the Insurance Act contributions proportionately, and to finance a National Medical Service out of taxation, national and local. The incidence of such taxation would, in the long run, be very much the same as that of the contributions under the National Insurance Act, the remitted or substituted portion of which would, therefore, counterbalance that increase in general taxation.
>
> " At the same time it cannot be denied, from the point of view of political expediency, that it might be unwise to hand back to the insured persons and their employers a sum of eight million a year, which they are now paying without complaint, only to re-levy the same sum in the form of increased taxation in some other direction which might be strongly resented. Furthermore, the insurance funds now contain an exceedingly large sum of money by way of accrued surpluses on the first two quinquennia, a large portion of which is proper to be used for medical and allied purposes. Some of this might well be utilised as a capital sum to defray in whole or in part such expenses consequent upon the inauguration of the National Medical Service as are of a capital nature, e.g., primary health centres, such as are contemplated in the Dawson Report, additional hospital accommodation, and conversion and improvement of existing hospital buildings, &c." (App. XIII, 46, 47.)

The " Means Test."

132. In connexion with these views we may give a brief outline of the operation of what is called the " means test " as it appears in the various health services. In the Insurance system

the £250 limit applies to non-manual workers : for the manual workers there is no limit whatever. But so far as medical benefit is concerned, Insurance Committees are empowered to prescribe an income limit applicable to all insured persons for whose medical benefit they are responsible. Where such an income limit is prescribed in any area, persons above that limit must make their own arrangements for receiving medical benefit, receiving the appropriate payment from the Committee's Medical Benefit Fund in aid of their own expenditure. We are not aware that any Committees have exercised this power, so that a well paid manual worker would, under the present system, receive medical benefit on the capitation system and thus be quite free of any means test.

133. Another restriction of a similar type is to be found in the requirement that a voluntary contributor with over £250 a year is not entitled to medical benefit at all, either under the capitation system or under that known as " own arrangements," and pays a reduced contribution accordingly. Whether this restriction is effectively administered we do not know, but in any case voluntary contributors form a very small class. This provision—although it then related to a lower income limit—was inserted in the Act of 1913 to meet the objections entertained by the Medical Profession against extension of the sphere of contract practice to persons who, though initially within insurable limits, might later pass beyond the range of income for which voluntary insurance was, in their view, designed. It may suffice to accord mention, in passing, to the somewhat similar provision governing the medical benefit of exempt persons.

134. These restrictions are significant as embodying in a very definite form the means test, even in a system which is in part—and so far as the voluntary contributor is concerned in a very large part—maintained by the contributions of the beneficiaries.

135. The medical service provided by the Poor Law authorities is an extreme form of the application of the means test. Closely akin is the medical *treatment* provided by the Education Authorities for school children though medical *inspection* is provided for all, just as elementary education itself is, irrespective of means. The treatment of physical defects and diseases is subject to strict inquiry into means and to proved inability of the parents to provide it themselves.

136. As exemplifying the opposite principle we may take the whole group of services which deal with what is known as " public health," e.g., sanitation, provision for dealing with infectious diseases, venereal disease and tuberculosis and the Port sanitary service. The cost of these services is defrayed out of rates and taxes and no consideration in any form is given to the means of those most directly affected. The

Maternity and Child Welfare service is subject in certain aspects of its work to a means test, but in other branches it is generally available to all who may care to make use of its facilities.

137. On a general survey of these instances it is possible to recognise a guiding principle running through the differences. Certain of the services are conducted not only in the interests of the individual but perhaps even more fundamentally for the general well-being of the community. Others again are of a much more personal kind and in these the interests of the individual constitute the sole end, and not merely an end incidentally promoted in seeking the public good. In the latter class of case where the interests of the individual are the dominant consideration, payment may legitimately be required of the individual if his financial circumstances so warrant. On the other hand, in the former type of case where in any event the general interests of the public would dictate the expediency of not leaving the individual unattended, it might be inappropriate to call upon the individual to defray the whole, or indeed any part of the cost incurred in respect of the service rendered to him. But we may suggest that this distinction, like the general distinction between public health and the health of the individual, from which it arises, is one on which, as time goes on, it must become increasingly difficult to insist.

General Conclusion

138. We have mentioned these problems in a general way because, although they are not of immediate practical importance, we feel sure that sooner or later they must be faced. Having indicated our views on the need for effective co-ordination of all the health services, whether at the centre or in the local administration, it is sufficient to leave particular problems, and especially those of a financial character, to be solved in the light of the developments of that considerable period which must elapse before full effect can be given to the general principles we have enunciated. In the circumstances of that time, financial considerations may have emerged, and social conditions may have changed, in a way that is difficult to forecast, and anything we may say now must necessarily be thus qualified. But, if we may venture to pronounce on this matter, we are of opinion that the difficulties of a composite support to a completed medical service from insurance funds as well as from grants and rates would be so considerable alike in their financial, administrative and social aspects that some more practical solution must be sought. In particular we feel sure that the wider the scope of these services, the more difficult will it be to retain the insurance principle. The ultimate solution will lie, we think, in the direction of divorcing the medical service entirely from the insurance system and recognising it along with

all the other public health activities as a service to be supported from the general public funds. Consideration would have to be given to the question of the classes of society for whom the service would be available and whether it should be so available on a free basis or with payments by insurance or otherwise. These, however, are problems which need not—perhaps cannot—be solved now, but may be fitly left over for those who, unlike us, will approach at close range to the great question of the Public Health Service of the future.

CHAPTER VI.

THE FINANCIAL BURDEN OF THE EXISTING SOCIAL SERVICES.

139. In the preceding Chapters we have described in a general way the various health activities of the Central Departments and the Local Authorities, their relations to each other, and the lines along which, as we think, development should take place. But we have hinted that, in connexion with the various proposals for the extension of the Health Insurance Scheme which have been brought to our notice, serious regard should, in our opinion, now and for some time to come, be given to the present financial and industrial position of the country. Our proposals, because they are thus conditioned, may appear to be of a restricted nature to the numerous advocates of substantial development. We therefore, at this point, think it desirable to make a brief reference to these conditions and to indicate why in our opinion they necessarily limit present progress.

The Burden of Unemployment.

140. The serious conditions prevailing in many of our industries and the grave embarrassments under which the central and local finances of the country are alike labouring, are too well known to call for elaboration here. But lest we should be thought wanting in a proper appreciation of the value of a large advance in the public arrangements for promoting the health of the community, we think it desirable to emphasise the factors which on any statesmanlike review of the problem before us point to the expediency of a policy of caution. In the foreground there obviously stands out the question of unemployment, which for a period of almost five years has doubtless been the gravest feature in the life of the community. The number of the unemployed is now about 1,200,000 and for the past two years has varied very little. The figure has been as high as 2,000,000. Even at 1,200,000 it is 11 per cent. of the working population registered at the Employment Exchanges. The maintenance of this huge number of workers and their dependants is a national burden, the responsibility for which has been accepted by the State and it is being borne at a cost of about £50 millions a year to the community (of which £13 millions is paid from the Exchequer). In 1913, the corresponding figure was only £2 millions and in 1920-1 £14 millions. Even though the contributions of employed and employers to the Unemployment Fund make up a large part of the sum required, it is nevertheless true that the

charge ultimately falls upon the resources of the nation. To that extent it necessarily reduces the possibility of imposing further large burdens for the purpose of promoting the national health. So long as funds available are limited there can, in our opinion, be no doubt as to the question whether expenditure should in the first place be directed towards the further promotion of health or to the provision of maintenance. For health and maintenance are not competing claimants for public expenditure. They are indeed closely related. Without maintenance there can be no health; it would be futile to seek to promote the health of those without the means of life. Those who are unemployed, their wives and their children must be fed, clothed and housed. Having regard to the existing provision for the promotion of health made by the Local Authorities and under the Insurance Scheme, large additions to the cash benefits and wide expansions of the scope of medical treatment, however desirable in themselves, must, in our opinion, definitely take a second place to the provision of the primary means of life.

Health Insurance and Contributory Pensions Charges.

141. The present appropriation for National Health Insurance is about £39,000,000 a year. The charge is spread over the employers, the employed persons, and the State, in the following way: employers, £14 millions; employed persons, £13 millions; the State, £7 millions. The balance of £5,000,000 is derived from interest on accumulated funds. But the total sum, from whatever source it may be immediately derived, is ultimately a charge on the productive capacity of the country. Similarly the Widows', Orphans', and Old Age Contributory Pensions Act, which has just come into operation, involves immediate annual charges of £11 millions, £11 millions, and £4 millions respectively on the three members of the co-partnership, a total of £26,000,000. Thus for the three schemes of social insurance now in operation, the total annual charge on the productive powers of the country is £115 millions, of which the charge on the Exchequer is about £24 millions.

The Burden of other Social Services.

142. The latest figures available from the Return annually submitted to Parliament showing the cost of public social services in Great Britain indicate that the expenditure on services other than those on an insurance basis is approximately as follows:—

Social Service.	Parliamentary votes and grants.	Local rates.	Other receipts.	Total.
	£	£	£	£
Public Education	46,100,000	34,100,000	6,400,000	86,600,000
Expenditure under the Public Health Acts :—				
(1) hospitals and treatment of diseases.	2,300,000	4,900,000	600,000	7,800,000
(2) maternity and child welfare work.	725,000	735,000	340,000	1,800,000
Old Age Pensions (non-contributory).	27,000,000	—	—	27,000,000
Housing of the Working Classes.	8,100,000	1,000,000	7,400,000	16,500,000
Poor Law Relief (including lunacy and mental deficiency).	4,000,000	38,000,000	4,000,000	46,000,000
	88,225,000	78,735,000	18,740,000	185,700,000

143. Insurance against liability under the Workmen's Compensation Act may also be properly included in this brief review. The annual expenditure under this head appears to be about £12,000,000, the whole of which falls directly upon the employers, but the greater part of it indirectly upon the community.

144. Thus, in total, the nation, in a time of great industrial depression, is meeting an annual charge for social services of about £308 millions, which is provided as to £112 millions from taxation, as to £79 millions from rates, and as to £98 millions by some form or other of insurance payment.

Evidence as to the Burden on Industry.

145. We have heard evidence from the National Confederation of Employers' Organisations on this aspect of the problem (Q. 24,543-24,548), and we direct attention also to the statement which they have submitted to us (App. CVII). That Confederation claims to speak authoritatively on behalf of the employers of the country, as it is a central body representative of the various great federations whose constituent members have in the aggregate an employment roll of about seven million workers. The witnesses informed us that the Confederation is recognised by the Government as the mouthpiece of the employers on all matters affecting the latter's industrial relations to their workpeople; and that it nominates each year, on the invitation of Your Majesty's Government, the delegate and technical advisers to represent British employers at the International Labour Conference at Geneva held under Part XIII of the Treaty of Peace.

146. From this organisation, as will be seen from the evidence, we have received the strongest representations that industry

cannot bear any further burden at present, and, indeed, that the need for some alleviation of the load is most urgent and could be readily realised by a substantial reduction of the contributions of employers and employed persons under the Health Insurance Scheme. They maintain "that there is a definite limit to the amount of money which any country can afford to spend in the providing of social services," and that "that limit has in Great Britain already been largely exceeded, and particularly so in the case of Health Insurance" (App. CVII, 6). They submit the following table to illustrate the relative position in the principal European countries and to show how heavy in comparison is the burden imposed on Great Britain in respect of five of the social services, viz.: Poor Law, Workmen's Compensation, Old Age Pensions, Health Insurance and Unemployment Insurance :—

Country.	*Cost of five Social Services per head of total population.* *Actual.* s. d.	*Per cent. as compared with Great Britain.*
1. Great Britain	78 6	100 per cent.
2. Germany	37 6	48 „
3. France	13 0	17 „
4. Czecho-Slovakia	11 0	14 „
5. Belgium	5 6	7 „
6. Italy...	3 6	4 „

147. Special reference is made by the Confederation to the increase of contribution required to finance the new Contributory Pensions Scheme. Even after allowance is made for the reduction in the Health Insurance contribution consequent upon the lowering of the age limit from 70 to 65, and the reduction in the Unemployment Insurance contribution which came into force at the same time, the net result is that the total weekly contribution for the Insurance Schemes has been raised from 2*s*. 5*d*. to 2*s*. 9*d*. in the case of men. At the former rate the employer bore 1*s*. 3*d*., whereas he now bears 1*s*. 5*d*.

148. The following tables show the details of the changes to which effect has recently been given :—

MEN.

Health and Pensions.

Year.	Health.		Pensions.		Total for Health and Pensions.		
	Employer.	Worker.	Employer.	Worker.	Employer.	Worker.	Total.
1925 ...	5*d*.	5*d*.	—	—	5*d*.	5*d*.	10*d*.
1926 ...	4½*d*.	4½*d*.	4½*d*.	4½*d*.	9*d*.	9*d*.	1*s*. 6*d*.

Unemployment.

Year.	Employer.	Worker.	Total.
1925	10*d.*	9*d.*	1*s.* 7*d.*
1926	8*d.*	7*d.*	1*s.* 3*d.*

WOMEN.

Health and Pensions.

Year.	Health.		Pensions.		Total.		
	Employer.	Worker.	Employer.	Worker.	Employer.	Worker.	Total.
1925 ...	5*d.*	4*d.*	—	—	5*d.*	4*d.*	9*d.*
1926 ...	4½*d.*	4*d.*	2½*d.*	2*d.*	7*d.*	6*d.*	1*s.* 1*d.*

Unemployment.

Year.	Employer.	Worker.	Total.
1925	8*d.*	7*d.*	1*s.* 3*d.*
1926	7*d.*	6*d.*	1*s.* 1*d.*

149. The National Confederation of Employers' Organisations go on to urge that a substantial measure of relief could be obtained by a reconsideration of the finances of the Health Insurance Scheme, which they maintain is over-financed for the normal purposes contemplated in the Act of 1911. With this aspect it will be more appropriate to deal in the following chapter. At present we are only concerned to submit a conspectus of the burdens thrown upon the Exchequer, the local rates and upon industry, by the operation of the various schemes for promoting the public welfare.

150. We have given prominence to this evidence because of the important part that employers as a class play in the collection of the insurance funds and the large financial contribution which they make to the Scheme. But we have also received a certain amount of evidence from parties less interested financially, directed to the view that, however desirable expansion may be, the rates of contribution should not in present circumstances be increased. For instance, the Ancient Order of Foresters (Q. 4168-4176) express the view that any increase in the rate of contribution for the purpose of meeting the cost of a statutory dental benefit would not be favourably received. The National Conference of Industrial Assurance Approved Societies (Q. 5074)

" would not recommend any step which would involve increased contributions or increased taxation." The Manchester Unity of Oddfellows (Q. 5784, 5790) think that " the contribution at the present time is just as high as the ordinary working man can afford to pay." The National Federation of Rural Approved Societies (App. XXIX, 19; Q. 11,407-11,418) state that any increase of the contribution would not be acceptable either to employers or to insured persons. Finally, the Scottish Board of Health say that, having regard to the industrial situation of the country, " it appears to the Board that an addition to the present insurance contribution, for however good an object such an addition might be, would be found extremely difficult and practically impossible to obtain " (App. CV, 9). In oral evidence Sir James Leishman added: " The condition of the country, and I am speaking specially for Scotland, although I suppose it would apply to England, is from the industrial and economic point of view serious. Public burdens are very heavy. There has been a recent Act put on the Statute Book which will come into operation at the beginning of the year which, in effect, adds to the insurance contribution. Having regard to all these considerations the Board, which has given very careful and sustained consideration to the terms of reference of this Commission, thought they could not put forward any proposition which involved an extra contribution just now " (Q. 24,324). " If you take Scotland especially . . . coal and iron have been very bad; engineering has been bad; shipbuilding has been bad and shipping is bad. There are one or two things such as whisky and linoleum which are better. But, broadly speaking, Scotland is possibly even harder hit in some respects than England. We have had to take into account that point of view " (Q. 24,325).

General Conclusion.

151. In concluding this brief review of the present financial burden of the social services, we desire to make it clear that we do not in any way deprecate or condemn either the volume or the application of that expenditure. A civilised nation must carry the burdens of civilisation; and prosperity—even material prosperity—fulfils itself in many ways. America, for example, though devoting great resources to public education and other general services, makes little or no public provision for social insurance. Being able to pay high rates of wages in consequence of her unique economic position, she leaves the provision against the individual casualties of life to the personal and voluntary effort of her workers. Our country, on the other hand, has chosen, and rightly as we think, to make several great schemes of social insurance an integral and permanent part of the national life. But while this principle may be accepted, it is clearly essential that a balance between the expenditure on these schemes and

the productive capacity of the country should, from time to time, be struck, even though this can probably be done only in a very general way and without reduction to any precise formula, of which, indeed, the conditions do not permit. If, ignoring such considerations of prudence, the rate of expenditure outruns in a substantial way the productive capacity of the country, the result must surely be to stultify the aims which the nation has set before itself. It is small consolation to a bankrupt to be told that his doctor's bills have been the main cause of his disaster.

152. These considerations are, we think, relevant to our reference in view of the wide and costly extensions of the Health Insurance Scheme which have been urged on us from many quarters. We have every sympathy for such proposals and every desire that this country should maintain that leadership in the provision of social services which it has certainly shown to the world. At the same time we feel that there may come a time, and that in fact there has come a time when the State may justifiably turn from searching its conscience to exploring its purse, and that in connexion with our present reference we are entitled to direct attention to this grave problem, and to frame our recommendations in the light—or the darkness—of the economic condition of the nation.

153. We therefore make the definite recommendation that only such extensions or modifications as involve no expenditure or can be met within the present financial resources of the scheme, should be considered as immediately practicable. This implies that, in our opinion, there should be no increase at the present time in the rates of contribution under the scheme. We consider also that the scheme should be self-supporting subject to the payment by the Exchequer of its present proportionate share of the cost of benefits and their administration, together with the cost of the general supervision of the Scheme by the Ministry of Health and the Scottish Board of Health. We recommend that beyond these charges no further liability should rest on the Exchequer in any circumstances. This would involve the repeal of the provision of the Act under which the Exchequer is contingently liable to make a contribution to the Central Fund.

CHAPTER VII.

THE FINANCIAL RESOURCES OF THE HEALTH INSURANCE SCHEME.

154. One of the most important points confronting us in the course of our investigations relates to the question whether the whole of the present financial resources of the National Health Insurance system are in fact required to provide for the existing benefits and the related cost of administration, or whether, as has been urged from some quarters and notably by the National Confederation of Employers' Organisations, there is an appreciable margin which might be made available for other purposes. As we have seen in the preceding chapter, the Employers' Confederation advocate very forcibly a substantial reduction in the rates of contribution. On the other hand, many responsible witnesses press for extensions of benefit in various directions. Before we proceed to examine this important question of the margin, it will be helpful to give a brief account of the financial structure of the Scheme.

The Financial Structure.

155. This need be attempted only in the broadest outline, as a detailed description of the financial machinery and of the numerous accounts relating to National Health Insurance is given in Section D of Appendix I to our Minutes of Evidence. That statement has been supplemented by oral examination (Q. 2127 to 2543) which revealed nothing of a substantial nature lending itself to adverse criticism. The financial machinery is undoubtedly elaborate in character and thus may offer difficulty to society officials untrained in accounting problems. But we are told that the actual work is not so complex as would appear on the surface (*Strohmenger*, Q. 2448), and that the Department strives to effect all possible simplification. In our opinion the arrangements are well devised and in general the machinery appears to work smoothly and effectively.

156. The revenue of the Scheme is derived from contributions and State grants. The contributions are in the main paid by affixing Health Insurance stamps to cards which have a currency of six months. For this purpose about £500,000 worth of stamps on the average are purchased week by week, by employers at Post Offices. The value of the stamps sold amounted in the year 1924 to some £27,000,000, and since the beginning of the Scheme in 1912 to the end of 1924 the receipt from sales of stamps amounted to upwards of £250,000,000. The Post Office pays over weekly the amount of these receipts to the respective National Health Insurance Funds. Employers on whom is imposed the responsibility for paying the full contribution affix

the stamps to the cards of their workpeople—the insured persons—from whose wages an appropriate deduction representing the employed person's contribution may then be made; and each insured person surrenders his card so stamped at the end of the half-year to his Approved Society, or to the Central Department if he is a deposit contributor. The cards which have thus been surrendered to the Societies are transmitted in bulk to the Central Departments and Societies are credited with the value of the stamps on the cards, after certain deductions, to be described later, have been made. The Central Departments thus act as bankers holding the credits of Societies.

157. The State grants are made in the form of a fixed proportion (at present two-ninths) of the expenditure on benefits and their administration.

Allocation of the Weekly Contribution.

158. The weekly contribution, as reduced by the Widows', Orphans' and Old Age Contributory Pensions Act, 1925, is 9*d.* for men and $8\frac{1}{2}d.$ for women. The following is the allocation of these contributions :—

	Men.	*Women.*
	d.	*d.*
Benefit Fund and cost of administration ...	$7\frac{4}{9}$	$7\frac{1}{5}$
Reserve values (interest and redemption)	1	$\frac{9}{10}$
Contingencies Fund	$\frac{5}{9}$	$\frac{2}{5}$
	9	$8\frac{1}{2}$

159. The sums credited directly to the Societies represent the aggregate amount of their contribution claims at the rate of $7\frac{4}{9}d.$ a week in the case of men and $7\frac{1}{5}d.$ a week in the case of women. The Societies are also credited with the contributions applicable to their Contingencies Funds (at the rates, respectively, of $\frac{5}{9}d.$ and $\frac{2}{5}d.$) subject to deductions not exceeding one-eighth for the support of the Central Fund. In the circumstances explained below this deduction is at present in abeyance and the full amount of the contributions apportioned to the Contingencies Funds is carried to the credit of the Societies.

160. The balance of the contributions represented by the Societies' returns, that is to say, the aggregate of the amounts produced by 1*d.* per contribution in the case of men and $\frac{9}{10}d.$ in the case of women, goes to form the fund for the redemption of reserve values and the payment of interest on outstanding reserve values. The need for these reserve values, which are book credits, and—what is, of course, more to the purpose—for their conversion into actual moneys which in due course will be available for the payment of benefits, arises in the following circumstances. The contributions were originally fixed at rates

estimated to be equivalent in value to the benefits in the case of persons entering into insurance at the age of 16. The liabilities undertaken were, however, of such a kind (since the average annual duration of sickness and disablement grows with age) that the contributions so determined were insufficient for persons becoming insured at all ages between 17 and 70, such persons comprising, of course, the vast majority of those who became compulsorily insurable at the outset. To provide for the deficiency the State undertook to meet the charges under the Scheme in respect of two-ninths (the original fraction in the case of women was one-fourth) of the cost of benefits and administration, leaving the Societies responsible for seven-ninths of the cost. The effect of this was to enable two-ninths of the whole income from contributions to be retained by the Central Departments and applied to meeting the extra liability arising from the element of age as explained above. It then remained necessary only to make such arrangements as would enable each Society to receive a proportion of this income commensurate with the ages of its own members and the consequent share of the total liability which it had undertaken. This was secured by granting for each person who entered into insurance at an age over 16 a reserve value representing the liability arising in his particular case, according to his age, and by directing that, from the retained income, interest on these reserve values at the rate of 3 per cent. per annum should first be provided, the balance of the retained income of each year being applied as far as it would go to redeem the reserve value credits still outstanding.

161. It was originally estimated that the redemption would extend over 15½ years, but as the result of alterations made in the Bill during its passage through the House of Commons this period was extended to 18½ years. Further alterations were made in the Statute by the Acts of 1913 and 1918 and among them the Contingencies Funds of the Societies, and the Central Fund, were created by diverting to these purposes part of the moneys hitherto applied to the service of reserve values; this diversion was made retrospective to the beginning of the Act. The effect was to reduce, very materially, the sums available for the redemption of reserve values and to extend the estimated period of redemption to about 35 years.

162. Later, changes came about in the position as to reserve values as the result of the increase of benefits and contributions made by the Act of 1920, and, in minor degree, as the result of the revision of the financial provision made for married women by the Act of 1922.

163. Lastly, by the Widows', Orphans' and Old Age Contributory Pensions Act, the responsibility of the Approved Societies to provide sickness and disablement benefits to insured persons of ages between 65 and 70 was removed as from January, 1928, with the effect of diminishing the aggregate amount of

their accrued liabilities, as actuarially valued, by about £37,000,000. In consequence of this change the portion of the contributions retained for the service of reserve values was reduced from $1\frac{2}{3}d.$ to $1d.$ a week (men) and from $1\frac{2}{5}d.$ to $\frac{9}{10}d.$ a week (women). The estimated amount of the reserve values outstanding at 31st December, 1926, is £61,000,000; it is expected that these credits will be redeemed, i.e., will be converted wholly into actual and invested assets, by about the year 1955.

164. As indicated in paragraph 159 above, the portion of the contributions which is applied to the Contingencies Fund is credited to the Societies. The Contingencies Fund of each Society is, in effect, a sub-account of the Society's Benefit Fund, and the amount standing to the credit of the account is carried to the Benefit Fund after each valuation. In the event of the valuation showing a deficiency the amount thus transferred from the Contingencies Fund is available immediately for the restoration of solvency; but if the valuation shows a surplus, the transferred sum must be retained until after the next valuation when, if the financial position permits, it is released and becomes part of the surplus available for the provision of additional benefits. The same provision applies with regard to any balance of a Contingencies Fund which may remain after making good a deficiency.

165. There are two exceptions to this method of dealing with the Contingencies Funds. In the case of a Society with Branches, although each Branch has its own independent Benefit Fund, the Contingencies Fund is common to the whole Society. It is required to be applied in the first instance to make good any deficiencies appearing on the valuation of Branches (subject to certain reservations in cases where deficiency is due to maladministration), any balance then remaining being distributed over the whole of the Branches in suitable proportions. The other cases of exception are those of Societies with less than 1,000 members. In these cases a proportion of the Contingencies Funds, not exceeding one-half, is liable to be called upon for the redemption of deficiencies among Societies in the group, thus ensuring that these small Societies which may be deemed to be liable to excessive fluctuations due to paucity of numbers shall have some further security beyond their own resources, additional to that which is provided for all Societies by the Central Fund.

166. The purpose of the Central Fund is to make good the whole or any part of a deficiency which remains unprovided for after a Society's Contingencies Fund is absorbed, or its rights against Contingencies Funds, as above explained, are exhausted, provided that the deficiency is attributable to causes beyond the control of the Society. It has been explained in paragraph 159 that a portion not exceeding one-eighth of the contributions to the Contingencies Funds may be retained by the Department concerned and credited to the Central Fund. In addition the

Central Fund is entitled to receive an annual Exchequer grant of £142,000 concurrently with the credit of the full sums authorised out of contributions. But under Section 68 of the Act this annual payment is reducible proportionately to any reduction which may be made in the contributions as a consequence of the financial position of the fund, and if the contributions are wholly suspended the payment from the Exchequer is suspended also. The Fund stood at £3,336,000 at 31st December, 1924, but against this balance there was a substantial liability in respect of part of the additional cost of medical benefit for the years 1925 and 1926 under the National Health Insurance (Cost of Medical Benefit) Act, 1924 (see paragraph 182 below), the effective balance of the Fund being about £1,500,000. On the first valuation there were only four calls upon the Central Fund, to a total of £8,750. The draft on the Fund having been so comparatively insignificant, the payment of contributions has been suspended since 1st January, 1921, and the Exchequer grant is, accordingly, in abeyance also.

167. The amounts credited to Approved Societies, Deposit Contributors, &c., or applied to the redemption of reserve values in respect of contributions paid up to 31st December, 1923, have been about £4,750,000 less than the receipts from the sales of stamps. The surplus is attributable to (1) stamps bought by employers but not yet affixed to cards, (2) cards stamped but still held by employers or Approved Societies, (3) lost stamps and unutilised stamped cards. The balance due to the first two causes is, we understand, estimated at about £1,500,000. This is considered to be a fairly constant amount from period to period, but it represents at all times an outstanding liability which will mature as soon as credit is claimed for the stamps of which it is made up, and it must be kept in hand accordingly. The balance attributable to stamps on cards which have not been and are not likely to be surrendered, or to loss of stamps by the public may have amounted up to 31st December, 1923, to more than £3,000,000. The bulk of this balance is required by the principal Act to be transferred to the Central Fund but, to meet a temporary difficulty, part of it was diverted to recoup Societies the arrears excused to members under the Prolongation of Insurance Act. In consequence of the question which had arisen in regard to the cost of medical benefit, the balance existing at 31st December, 1923, so far as not otherwise appropriated, was, in effect, applied by statute towards meeting that cost up to 31st December, 1926.

The First Valuation.

168. The first valuation of the assets and liabilities of the Approved Societies was made as at 31st December, 1918. Full details of this valuation will be found in the Report of the Government Actuary (Cmd. 1662). The total number of

valuations of Societies and Branches in the United Kingdom (including Ireland) was 10,162, the total membership being 16,250,778. The accumulated funds of Societies at the valuation date amounted to £119,479,279, of which reserve values outstanding represented £64,017,994. The valuations showed an aggregate surplus of £17,192,968, this sum being the difference between total surpluses in 9,745 cases amounting to £17,273,887, and total deficiencies in 407 cases amounting to £80,919. In 10 cases the assets and liabilities were of equal value. The average amount of surplus was £1·08 per member, taken over the membership of the cases in which the surplus was found, while similarly the average amount of deficiency, taken over the cases in this category, was £·25. Of the total surpluses of £17,273,887, amounts aggregating £9,184,087 were certified by the valuers to be disposable in the provision of additional benefits, leaving sums amounting in total to £8,089,800 to be carried forward to the next valuation. In addition to these amounts there were also carried forward Contingencies Funds approximating closely to £6,500,000, the total of the sums carried forward thus being about £14,600,000. Of this sum about £14,000,000 may be attributed to Great Britain.

169. The total amount credited to the Benefit Funds of Approved Societies in respect of contributions from the commencement of the Act to 31st December, 1918, is estimated to have been about £87,000,000, and the aggregate surplus therefore represents 20 per cent. of the contributions received up to the valuation date. This striking and, in great measure, unforeseen result of the first stocktaking operation is attributed preponderantly to conditions set up by the Great War. What these conditions were, and what was their effect, is shown in considerable detail in the Report of the Government Actuary, and it is unnecessary for us to discuss them at any length. It is sufficient to say that the claims upon the funds for sickness and disablement benefits were below the "expectation" to an amount of £10,000,000; that maternity benefits cost £1,700,000 less than the sum provided for; that interest on investments produced £1,600,000 in excess of the yield required by the basic rate of 3 per cent.; and that interest on the growing surplus accounted for £1,200,000. In respect of each of these items, the Report referred to finds the governing factor in the profound and universal disturbance of the normal life of the community in the years over which the gigantic conflict extended. We lay stress on this conclusion because it precludes us from assuming anything as to the existence of a margin in the contribution from the results of the first valuation.

The Second Valuation.

170. The second valuations, which relate to Great Britain, are still in progress, and their complete results are not expected to

be available for some months. We are, however, given to understand that they are likely to show aggregate surpluses of between £40,000,000 and £45,000,000, of which about £17,000,000 is due to the sums carried forward from the previous valuation with their subsequent interest earnings. Much information as to the progress of the Societies in the inter-valuation period is contained in a statement which the Government Actuary's Department has submitted to us with reference to the valuations made as at 31st December, 1922 (App. LXXXVII). These cases comprise 3,981 units (Societies and Branches) and show surpluses amounting to £8,500,000 against deficiencies totalling £9,000 only. The average amount of surplus over a membership of 2,850,000 is nearly £3 a head; the average deficiency, in respect of under 11,500 persons, is 15*s.* 11*d.* It is possible that the units first valued do not constitute a wholly representative sample of the whole, but when due allowance is made for this we are justified in expecting that the results of the second valuation will be even more remarkable than those of the first. We are informed that, of the surpluses expected to be revealed, it is estimated that sums amounting to about £15,000,000 will be carried forward and £25,000,000 to £30,000,000 applied to additional benefits.

171. We are naturally concerned to ascertain the causes of what we must call such phenomenal progress. We learn from the statement mentioned that the claims have been but 71 per cent. of the expectation in the case of sickness benefit, 61 per cent. in the case of disablement benefit and 78 per cent. in the case of maternity benefit; that interest in excess of the product of 3 per cent. and interest on surplus have yielded over 11*s.* a head in the four years 1919-22, that appreciation of securities is an item of some consequence, and that a substantial sum is attributable to cessations of insurance with consequent lapse of rights in respect of additional money benefits granted after the previous valuation.

The Margin in the Present Contribution.

172. General indications of these features of the present position were brought to our knowledge at an early stage of our deliberations. They raise the question whether with the lapse of time sufficient changes have occurred in the conditions governing the finance of the system of National Health Insurance to justify a re-arrangement of its financial basis, with the object of providing resources either for the enlargement of the statutory benefits or for meeting expected additions to the cost of any of the existing benefits. This, of course, is a technical question and that it might be examined authoritatively we requested the Minister of Health to set up the Actuarial Committee to the appointment of which we have previously referred. That Committee has presented three Reports which we print as

an Appendix on pp. 330-383. With reference to the first and principal of these Reports it will be observed that the Committee was asked to advise "as to whether the present basic contribution under the National Health Insurance Acts is, in fact, required for the existing benefits (including the cost of Societies' and Insurance Committees' administration) or whether such a re-arrangement of the financial basis of the scheme would be justified as would reduce the amount allocated to the present benefits and leave a margin for other purposes."

173. The Report of the Committee shows that they have systematically analysed every element which enters into the financial basis of the system. It is unnecessary for us to traverse the whole field of their deliberations and we content ourselves, in this connexion, with a reference to two of the most important points with which they had to deal, namely the rate of interest at which the funds of the Approved Societies may be assumed to fructify hereafter by investment, and the rates of sickness and disablement to which the individual insured persons should be taken to be subject (on the average) as they pass from age to age.

174. On the first of these points the Committee bring out the fact that on actual securities (including securities representing the moneys in the National Health Insurance Investment Account which are held by the National Debt Commissioners) the average rate of interest at present yielded is between 4½ and 5 per cent. These securities represent about 55 per cent. of the interest-bearing assets, the remainder being accounted for by reserve values, which, under the plan described above, carry, by statute, the rate of 3 per cent. The average rate obtained in recent years has thus been something under 4 per cent. The Committee go on to explain, however, that the real funds are continuously increasing in amount while opportunities of investing the increments at high rates of interest remain, and for a long period are likely to remain, abundant; and that on the other hand the low-yielding reserve values have been heavily diminished by the provisions of the Widows', Orphans' and Old Age Contributory Pensions Act of 1925, and will be reduced still further by other changes, resulting partly from the Committee's proposals and partly from the cancellation or redemption of several millions of these credits in the application of the regulations as to balances in the Reserve Suspense Fund. They have, therefore, satisfied themselves that the average rate of interest obtained will immediately rise above 4 per cent. and they expect it to remain at or about that figure for the next 30 years, after which an opportunity for reconsideration of the rate will, in any case, present itself. They accordingly propose that in the new financial basis of the system the rate of interest taken shall be 4 per cent. per annum instead

of the present rate of 3 per cent. It should be noted that this proposal involves no change in the rate of 3 per cent. which is credited on reserve values. It is also worthy of observation, as bearing upon the Committee's recommendation, that the interest income of Approved Societies is not subject to income tax, and that regard may consequently be had to the gross rate earned.

175. With reference to the average annual rates of sickness and disablement for which provision should be made, the Committee draw attention to the fact that while among both men and women the claims for sickness benefit have been below the "expectation" of the present basis in the years 1919 to 1924 there are disquieting features in the course of the claims from year to year, especially among women. In the case of disablement benefit the Committee evidently look with concern upon the rapid increase in the claims which they have found and from which it appears that among both men and women the cost of this benefit in relation to the expectation, has doubled itself between 1919 and 1924. It is evident that the Committee have met with difficulty in dealing with these elements in the situation, and so far as women are concerned they have found themselves precluded from coming to a final decision. They propose, so far as relates to men, to retain the Manchester Unity Experience, 1893-97, on which the present basis in respect of sickness and disablement is founded, but to eliminate the addition of approximately 13 per cent. to the Manchester Unity rates for which that basis provides. In regard to women, they propose to discard the present basis and to substitute a new basis drawn from the experience of a large sample of the female insured population in the year 1923, with a loading of 10 per cent. to the sickness rates thus obtained. The explanation of the choice of a single year's experience for this purpose instead of that of the three years 1921-23 which the Committee examined, is that the claims were rising steadily throughout the three years, with the result that the experience of 1923 was sensibly higher than the average of the whole period. The Committee explain that in fixing the loading at 10 per cent. they have had regard to certain small margins which they find to be available for the assistance of the Societies.

176. With reference generally to the experience of sickness and disablement claims which the Committee examined, they draw our attention to a Memorandum appended to their Report which contains the results of a study by the Government Actuary's Department of some of the more difficult features which this experience presents. They consider that these results should be examined, with a view to effective action, by the responsible Departments, and we concur in this opinion. The features to which attention is directed are evidently widespread and they should receive the serious attention not only of the Departments

but also of the Societies, which have a direct and legitimate interest in the claims upon their funds for sickness and disablement benefits. We cannot but feel that statistical inquiries of the kind for which the present investigation has provided the opportunity may be of the greatest value in aiding efficient administration, and we would recommend the systematic institution of such inquiries, to be followed, systematically also, by conference with the Societies upon such features of apparent significance as the inquiries may reveal.

177. The importance of this subject is emphasised by consideration of the Committee's Report in another aspect. We shall proceed immediately to discuss the margin in the contributions which the Committee find to be available for new purposes, and we shall be compelled to indicate at various points in this Report that we are restricted, in our recommendations as to various extensions, by the comparatively small sum which remains after provision has been made for certain additional liabilities which must in any case be met. It was, perhaps, too early in the history of the Scheme, especially having regard to the abnormal conditions which have prevailed for a considerable part of the time during which it has been in operation, to have expected that the question of the margin in the contributions could be permanently settled at the present time; and from this point of view we might reasonably look forward to the results of another investigation after further experience, under more settled conditions, has been gained. But it is evident that if the upward tendency in certain of the claims for money benefit cannot be brought under control, there is little prospect of more money being released for new purposes at a later date. It is clear that the best interests of the Scheme would be served if a basis for hope, in this connexion, could be developed. Considering the beneficial results on the health of the insured community which ought to follow from the medical service provided by the Act, and considering also the general advance in the education of the people and the greater appreciation of hygienic conditions which, as a result, is being disseminated, we feel that it is not unreasonable to look for improved conditions so far as the claims are concerned. But we realise that such an improvement may not be fully secured without a general and definite endeavour to keep the claims within their proper limits, regard being had, of course, to the just and equitable treatment of the insured persons. Systematic attention to the statistical results of the Approved Societies' work would assuredly promote the realisation of that improvement and should accordingly be given a prominent place among the matters of administration to which the attention of the Departments and the Societies is continuously directed.

178. The effect of the Committee's proposal, so far as relates to the contribution payable to the Benefit Fund is to reduce the

rate in the case of men from 7·44*d.* to 6·55*d.* and in the case of women from 7·20*d.* to 6·85*d.*, thus releasing weekly ·89*d.* from the man's rate and ·35*d.* from the woman's rate. It will be noticed that, as reduced, the woman's contribution is higher than the man's, although the woman's benefits are the lower. The Committee point out that this is the direct result of the heavy sickness and disablement claims among insured women. A further consequence of the change of basis is to reduce the reserves required at all ages over 16, and the Committee propose to utilise this element of relief to diminish the reserve values. They further bring into account the balance of the Reserve Suspense Fund, which is estimated to grow to £17,000,000 by 31st December, 1926. Under existing regulations—which they assume will be applied in their integrity—this balance is to be applied to the cancellation or redemption (as the case may be) of reserve values, and in the normal course would have the effect of shortening the redemption period. The Committee see no reason for this curtailment of the redemption operations, and accordingly propose to utilise the reduction of the reserve values, under both the heads just mentioned, to diminish the part of the contributions which is retained to provide interest on and the redemption of reserve values. The reduction thus obtained is ·35*d.* from each weekly contribution in the case of men and ·32*d.* in the case of women. Finally, in this connexion, the Committee examine the part of the contribution which is paid to the Contingencies Funds, and arrive at the conclusion that it may properly be reduced to a farthing a week in the case of all members of Approved Societies, whether men or women. The release from the weekly contribution under this head is therefore ·31*d.* (men) and ·15*d* (women).

179. The total result of all the above proposals would be to set free out of the present contribution an amount of 1·55*d.* a week in the case of men and ·82*d.* per week in the case of women. In order that the effect of this may be clearly seen the Committee explain that, after allowing for the State grant of two-ninths, these sums would provide, throughout life, 7*s.* a year in the case of men and 3*s.* 9*d.* a year in the case of women, which amounts would thus become available for purposes for which no present provision is made from Societies' funds. These latter figures would not, of course, afford assistance in the consideration of any form of expenditure, e.g., an addition to sickness or disablement benefit, which involved a variation of the charge with reference to age or family responsibility.

180. The Committee point out that the effect of applying the sums released for any new purposes would be to absorb about £15,000,000 of Approved Society funds in the course of a quinquennial period. The chief result of this, no doubt, would be to reduce the surpluses of Societies at succeeding valuations by

something approaching this amount; but a secondary effect of some consequence would be to throw into deficiency a number of Societies which at present have no surplus or only small surpluses, and are consequently unable to meet any additional strain on their resources. The Committee estimate that Societies comprising about 10 per cent. of the whole insured community might be placed in this position and they recommend, accordingly, that any balances accruing to the Reserve Suspense Fund after 1926 should be utilised to give sufficient financial assistance to Societies of this class to enable them to maintain a condition of solvency

181. The Committee point out that their proposals do not involve any draft upon the accrued surpluses of Societies which, with the related Contingencies Funds, and apart from surplus in course of distribution under current schemes for additional benefits, must amount, they estimate, to something considerably in excess of £35,000,000 at 31st December, 1926.

First Call on the Margin.

182. The margin in the contribution which results from the Committee's proposals amounts in all, with the related State grant, to about £4,500,000 a year. The first charge on this amount must, we think, be the balance of the cost of the present medical benefit, *i.e.*, the excess over the sum of 9*s.* 6*d.* per insured person per annum for which provision is made in the Consolidation Act of 1924. Temporary provision for defraying this balance from various sources for three years was made by the Cost of Medical Benefit Act of 1924 (see paragraph 142, Section C of Appendix I to our Minutes of Evidence). But even were it desirable to continue to have recourse to similar expedients in future it would be impossible to rely on money being available from the same sources, more especially in view of the fact that the present temporary provision is likely to prove inadequate in England and Wales, and that the consequent deficiency must, in our opinion, be met by an increase of the temporary provision referred to. On the official evidence before us, the sum which it will be necessary to provide to cover the whole cost of the present medical benefit after 1926 will be 12*s.* 6*d.* per insured person per annum. We recommend that the whole of this sum should be provided in future from the funds of Approved Societies, as in the case of benefits in general. A problem of draftsmanship will no doubt arise in framing the statutory provision so as to meet the continuing difficulty in estimating the annual cost of drugs. In this connection reference may be made to the evidence of Mr. Brock and Dr. Smith Whitaker (Q. 23,993).

Application of Balance of the Margin.

183. If the above recommendation be adopted the margin of 7*s.* 0*d.* in the case of men, and 3*s.* 9*d.* in the case of women, will

therefore be reduced to a sum of 4*s.* 0*d.* a year in the case of men and 9*d.* a year in the case of women throughout life, or the equivalents of these amounts in the event of the adoption of a form of benefit which does not involve an equal expenditure in every year of insured life. The main question for consideration is the manner in which this balance in the margin should be applied. The following possibilities emerge :

(1) It could remain as a margin, in which case it would serve to strengthen the financial position of all Societies on valuation, affording permanent support for additional benefits, in the case of what, we hope, will continue to be the great majority of Societies.

(2) It might be applied towards the cost of one or more of the various extensions of the statutory benefits which have been suggested.

(3) It might be used to reduce the cost of the Scheme to one or more of the three contributing parties, viz., the insured persons, the employers and the State.

184. There is something to be said, no doubt, in favour of the first of these courses, bearing in mind, particularly, the features of the sickness and disablement experience to which the Actuarial Committee have drawn attention. But in view of the fact that the Committee, relying, no doubt, on the exercise of effective supervision of the claims, express the opinion (in paragraph 29 of their First Report) that the whole of the margin may be applied to new purposes, we do not think it incumbent on us to recommend that any part of it should be retained as a provision in respect of present liabilities.

185. With reference to the second of the three alternative courses, we deal in Chapters X to XII with the various forms of extensions of benefit which have been recommended to us, and indicate, in regard to those which we regard as practicable, the extent to which the available margin would render their adoption possible, at the same time stating the order of priority in which, in our opinion, the various alternative extensions should be placed.

186. As regards the rates of contribution, a reduction of 1*d.* in the joint weekly contribution of 9*d.* in the case of men would be possible if such reduction could be deemed to be expenditure on benefits for the purpose of attracting the State grant, but the division of this 1*d.* between the employer and the worker would probably be objectionable to employers, as it would involve the deduction of an odd $\frac{1}{2}d.$ from wages. If the whole 1*d.* were taken off the worker's contribution, the result would be that the deduction from the wages of an employed woman for Health Insurance would be 4*d.* as against $3\frac{1}{2}d.$ in the case of an employed man, though the woman's rate of sickness benefit is lower than that of a man. The deduction of the whole 1*d.* from the

employer's share of the contribution would be possible, but would probably give rise to dissatisfaction as reducing the employer's share of the joint contribution below that of the worker, a position which, in any case, would be inconsistent with that existing in the case of women, where the employer pays for the combined health and pension benefits 1*d.* a week more than the worker. These difficulties in the way of devising any reduction of contributions which would be free from serious objection preclude us from recommending that the margin should be utilised in this way. In coming to this conclusion we are assisted by the fact that, in view of the small margin available, no reduction of the contribution would be possible, in any case, in respect of women.

187. There remains the possibility of using the margin, or part of it, to reduce the charge upon the State. We do not regard it as falling within our province to consider whether such a reduction should be made, but we have been impressed by the extent to which the original conditions under which the State grant was fixed have been altered by subsequent events, and we think it incumbent on us to explain the situation as it presents itself to us.

188. We have shown in paragraph 160 that the State grant was fixed at two-ninths of the benefits in consideration of the imposition upon the contributions of the insured persons and their employers of the liability to provide the necessary reserves in respect of seven-ninths of the benefits for the population brought into insurance at the outset. It followed from this arrangement that from the increase of benefits in 1920 up to 31st December, 1925, the charge upon the contributions for this purpose was $1\frac{2}{3}d.$ a week in the case of men and $1\frac{2}{7}d.$ a week in the case of women. By the Pensions Act of 1925 these rates were reduced, respectively, to 1*d.* and ·90*d.*, while the Actuarial Committee recommend, in connexion with the change of basis, that if the margins are applied uniformly over life, as explained above, they should be further reduced to ·80*d.* and ·60*d.*, respectively.

189. Reductions of over 50 per cent. in the contributions of the insured for the redemption of reserve values are thus envisaged. At the same time the Exchequer continues liable to provide its correlative grant of two-ninths of the expenditure on benefits, and this is only to be abated by the cessation from 1928 onwards of the grant in respect of sickness and disablement benefits to persons aged between 65 and 70, a relief which amounts to no more than 7 per cent. of the full charge. The disparity between the relief which is to accrue to the insured persons and that which the State obtains on its related obligation is emphasised by certain of the causes to which the reduction in the reserve values is due. These are the provision of pensions at the age of 65, which has imposed a heavy charge on the State, and the increase in the rate

of interest due to the War which, as all are aware, has added enormously to the burdens of the taxpayer. The remaining cause of the reduction is the lapse from insurance of a considerable proportion of those who were brought within the Scheme at the outset and in respect of whom reserve values, which have subsequently been withdrawn, were provided.

190. The balance of margin in the contribution may be estimated as equivalent, with the appropriate State grant, to £2¼ millions a year. This margin is due to extraneous causes, among the most important of which is the general increase in the rate of interest on post-War investments, to which we have referred above. No income tax is payable on the interest earnings of Approved Societies, and the members of those Societies, accordingly, secure the full benefit of this increase and are able to claim additional State grant in respect of a rate which itself reflects the weight of a national burden from which they are free. Having regard to the fact that the additional resources made available to the insured in this way and in the appreciation of investments which has already been realised will go almost in their entirety to supplement the benefits originally provided by Parliament, it is clear that the relations between the general body of insured persons and the Exchequer are more favourable to the former than has been generally supposed hitherto. While we have felt bound here to explain the situation in which this result arises, we do not desire what we have said to be regarded as qualifying the recommendations which we make in later chapters of our Report in regard to the application of any margin in the existing scheme.

191. We have recommended, in paragraph 182, that the cost of medical benefit, not hitherto borne by the funds of Approved Societies and expected to amount in future to about 3*s.* a year for each insured person, should now be placed upon those funds. On this recommendation a question arises with reference to the rate of contribution for men who are serving with the Forces of the Crown and to the special foreign-going rate of contribution for men of the Mercantile Marine. These rates of contribution are reduced, in each case, by the equivalent of the normal benefits which are not provided for insured persons in the classes to which they respectively relate, and, as a consequence, the rate for men in the Forces is 3½*d.* a week instead of 9*d.*, and the foreign-going seaman's rate is 7*d.* instead of 9*d.* One of the benefits not provided for men who are serving with the Forces is medical benefit: so far as the Mercantile Marine is concerned, this benefit is not provided for a man while he is on foreign articles, and the liability for any medical attention that he may require rests upon his employer under the provisions of the Merchant Shipping Act, 1894. When, therefore, the cost of medical benefit in the case of civilian insured persons is increased, the reductions already made from the normal contribution in the case of these special

classes should be increased, the special rates of contribution thus being diminished. The question is a little complicated, because sickness benefit is also one of the benefits withheld in the circumstances indicated, and under the proposals of the Actuarial Committee the provision to be made in future for this benefit is to be slightly decreased. After bringing this into account, we are informed that the reduction from the civilian contribution, in the case of both the classes under discussion, should be increased by $\frac{1}{2}d.$ a week. Accordingly, the special rate for the men serving with the Forces should in future be $3d.$ a week instead of $3\frac{1}{2}d.$, and the rate for foreign-going seamen should be $6\frac{1}{2}d.$ instead of $7d.$ The fraction of three-sevenths, mentioned in the proviso to Section 62 (3) of the Act of 1924, should become three-fifths.

192. The same point arises in respect of the extensions of benefits which may be provided from the other part of the margin released under the recommendations of the Actuarial Committee. In so far as this margin may be applied to the provision of benefits which the man serving with the Forces cannot obtain, the contribution paid for him should be reduced correspondingly. Similarly, if in any material degree the foreign-going seaman is debarred by the conditions of his employment from obtaining the new benefits the contribution paid for him should be adjusted. But until the new benefit has been definitely selected its incidence at the ages of the men concerned cannot be estimated and its effect on the contributions of these special classes cannot be computed. At the present stage, therefore, we must content ourselves with drawing attention to this point.

193. A similar adjustment is necessary in the case of a voluntary contributor with an income exceeding £250 a year. Such a contributor is not entitled to medical benefit, and the Act provides that, in consideration of this, a reduction of $2d.$ a week is to be made in the contribution payable by him. This amount represents approximately the payment (viz., $9s.$ $6d.$ a year), which is made out of the funds of Approved Societies in respect of the cost of medical benefit for each of their members. If, in accordance with our recommendation, this sum of $9s.$ $6d.$ is increased to $12s.$ $6d.$, the reduction of $2d.$ a week should be correspondingly increased to $3d.$

Financial Readjustments.

194. On the more technical points brought to our notice by the Actuarial Committee, we are naturally inclined to follow the expert professional advice offered to us, and we accordingly make the following recommendations :—

(1) That Section 67 of the Act should be amended to provide that the amount of the weekly contribution to be devoted to providing interest on and redemption of reserve values be reduced from $1d.$ in the case of men and from nine-

tenths of 1*d.* in the case of women to such amounts as may be actuarially shown to be necessary, without disturbing the redemption period, after the charges and readjustments have been settled.

(2) That the Section should also provide that the amount of the weekly contribution to be retained for the purposes of the Contingencies Fund and the Central Fund should be reduced from five-ninths of 1*d.* to one farthing in the case of men and from two-fifths of 1*d.* to one farthing in the case of women.

(3) That the normal proportion of these reduced sums to be paid to the Central Fund should be increased from one-eighth to one-fourth.

(4) That Section 76 (5) of the Act be amended to provide that, consequentially on the reduction of the contribution to the Contingencies Funds, the whole (instead of a maximum of one-half) of the balances of the Contingencies Funds of all Societies with less than 1,000 members should be liable to be pooled to make good deficiencies in any such Societies.

(5) That the balances accruing to the credit of the Reserve Suspense Fund after 31st December, 1926, be made available for averting deficiencies which would otherwise arise on the valuation of Approved Societies by reason of the imposition on their funds of the new charges.

An Alternative Financial Scheme.

195. Reference may conveniently be made in this Chapter to an alternative financial scheme to that at present in force which has been submitted to us by Mr. Walter Farris and upon which we had the benefit of hearing Mr. Farris in person. Mr. Farris's proposal is based upon the proposition that the structure of the Act on its financial side is productive of much unnecessary labour and expense, and that, in his own words, " if we could only break away from this actuarial system much of our labours and troubles would disappear " (App. XCIV, 3). We cannot attempt to give an exhaustive explanation of the plan which Mr. Farris has submitted, but broadly it is that the reserve values should be abolished and that Societies should cease to be credited with the contributions of their own members or of any sums in redemption of reserve values, being credited yearly in lieu thereof with the amounts estimated to meet the cost of normal benefits to their members during the following year; such amounts being computed in each case on the actuarial basis of the Act and in accordance with the ages of the members of the Society or branch. Incidentally, the scheme would require, as Mr. Farris admitted (Q. 22,323-22,332), the transfer to the Central Departments of all the securities in the hands of the Societies representing funds invested by their own trustees and amounting at the present time to between £40 and £50 millions. In this direction, therefore, the proposal would eliminate one of the most

important elements of self-government as existing under the present system. We cannot think, after examining this proposal, that it affords any promise of curtailment of work, since while some accounting and actuarial operations would cease to be necessary, others would take their place. Nor do we think that the proposal is to be recommended on its merits otherwise. By the substitution of the year for the quinquennium as the unit of time in regard to which the benefits are actuarially regulated, it would conduce to a frequency of change in the benefit arrangements from which under the present system they are free, while it would create problems of particular difficulty, and as the scheme was expounded to us would certainly result in the relaxation of control, in regard to those Societies that are expending in benefits much more than the general average. We therefore consider that there is nothing in the scheme or in the reasons put forward in its support to warrant us in recommending its consideration.

CHAPTER VIII.

THE APPROVED SOCIETY SYSTEM.

196. We now turn to consider one of the most important features of the Scheme of National Health Insurance—the Approved Society system. Whether we regard the membership of the Societies, or their number and variety, or the historical position which many of them occupy in the field of provident effort, or the immense sums of money with the administration of which they are entrusted, we are impressed with the magnitude of the system and the complexity of the many issues which it presents for our consideration. We think it will be convenient to discuss these problems as a self-contained group, remembering that we deliberately excluded them from our review in Chapters V and VII. Accordingly in this Chapter we describe the system, give the effect of the more important evidence we have received in regard to it and make certain recommendations for improving the administrative working of the system, which, in its main features, should, we think, be continued.

Autonomy of Societies.

197. In one respect the National Insurance Act of 1911 represented a bold experiment in the field of social legislation, inasmuch as it sought to devolve a large part of the administration of a measure enacted by Parliament upon those in whose interests the Act had been passed. Even a cursory perusal of the Act would demonstrate that in intention at least the Health Insurance Scheme was planned so that it might be administered, not by the executive departments of the Central Government or by Local Authorities subject to the electorate at large, but as far as might be by self-governing bodies created by and answerable to the insured persons themselves. The Act was thus an experiment in democracy, no less than in the domain of social betterment, and a review of the working of the Act would be incomplete if it failed to recognise this two-fold character of the Scheme. The bodies by which the Act, so far as concerns the administration of cash benefits, is administered, are known as Approved Societies. They are organisations of various origin and differ widely from one another in constitution and methods of operation. They are, however, subject in common to two main statutory conditions, namely—

(1) That the Society shall not be conducted for profit, and

(2) That its constitution shall provide for its affairs being subject to the absolute control of its members.

198. The Act provides that each Approved Society shall have control of its own funds derived from the contributions of its

members and their employers, and that any surplus disclosed on the periodical valuation of its assets and liabilities shall remain at the disposal of the Society to be used only in the provision of additional benefits for its own members, as those members shall determine. The institution of the Approved Society system was doubtless due to the fact that long before the provision of monetary aid for the worker in times of sickness and disablement, or of the necessary medical treatment for his restoration to health was accepted as a subject of public responsibility, the want had been met to a large extent by the provident efforts of the people themselves. These effects were expressed in the institution of the Friendly Societies which existed in almost every part of the country and of the benefit side of the Trade Union movement which was almost equally widely distributed. The majority of these bodies were firmly established and well organised, and enjoyed in their operations the protection conferred by various Acts of Parliament. So considerably had these movements appealed to the wage-earning classes that at the time when the Act was passed they were estimated to include among their members about one-third of the total population to be brought within the scope of the National Scheme. It was evidently felt that the use of these existing agencies would be of the utmost assistance, in bringing the new Scheme into operation and indeed that a Scheme which failed to build upon the foundation already laid by voluntary action of such a widespread character would have but little prospect of successful survival.

199. In a sense, therefore, it may be said that the adoption of the Approved Society system was not merely imposed on Parliament in 1911 as an essential condition of a workable scheme in the conditions of the time, but that it was justified by the necessity of retaining under a scheme imposed by the State the general features of a system of Insurance which had been evolved by the people themselves in their voluntary and unprompted efforts to meet their own requirements.

Numbers, Types and Membership of Societies.

200. Approved Societies are of many different types, the chief being Friendly Societies (with or without branches), Trade Unions, Societies formed by Industrial Assurance Companies or Collecting Societies, and Employers' Provident Funds for persons in the service of particular employers.

201. In the first draft of the Bill of 1911 a minimum membership of 10,000 insured persons was required as a condition of the approval of a Society, but this limit was abandoned before the Bill became law, and it was left open to any body of insured persons, however small in number, to apply to become an Approved Society. As a result, the number of Societies which secured approval at the commencement of the Scheme was very

much greater than had originally been contemplated, and included many with a very small membership. In England alone over 2,200 separate Societies had been approved within six months of the commencement of the Scheme.

202. While the fullest use was attempted to be made of the bodies already in the field when the Act was passed, a short experience proved that in many cases, especially among the smaller Societies, the purpose would be defeated by a certain lack of adaptability on the part of some among those who would thus be brought into the work of administration under the national system. Though much was done to ease the situation by utilising existing methods, the new machinery was different in certain essential matters from that to which the officers of the Societies were accustomed. Contributions were not, for instance, paid in cash to the Society and applied directly to the benefit needs of the members. They were paid by employers through the medium of stamps and passed from the Post Office to the coffers of the Departments, the Societies afterwards claiming their " credits " in the departmental books on the vouchers represented by their members' contribution cards. It followed that to place the Societies in a position to pay the benefits, funds had to be issued to them at stated intervals by the Departments. This procedure, with its accounting requirements, though not in itself involving any particular difficulty, proved to be irksome to many, while the need to conform to the standard of precision and promptitude entailed by the requirements of an Act of Parliament was equally burdensome. The result was that among the smaller Societies many officials decided that the task of administering National Health Insurance was beyond their powers, and as it was impossible to replace a considerable proportion of them from among their fellows, transfer of engagements, on a considerable scale, resulted. Mainly for this reason there has, from the first, been a continuous and considerable decrease in the number of Societies remaining approved. In England alone, out of 2,208 which had been granted approval no fewer than 1,192 had ceased to administer the Act by the end of 1923. At the present time the number of Approved Societies is 886 in England, 94 in Scotland, and 40 in Wales. Of these 31 are Societies with branches, the total number of branches for the purposes of National Health Insurance being 6,887. The actual number of " units " administering the system is thus 7,876.

203. The membership of Approved Societies varies within the widest limits from less than 50 to more than 2,000,000. In England there are still at one end of the scale 70 Societies with less than 100 members, and at the other end there are 24 Societies with a membership of over 50,000 including two with over a million members in each. We were informed

that 65 per cent. of the total number of Societies in England comprise only 2 per cent. of the total number of insured persons, while 2½ per cent. of the Societies include 76 per cent. of the insured persons. (*Kinnear*, Q. 23,553.)

204. Approved Societies are not, as a rule, organised on any territorial basis, and while a certain number are restricted to persons engaged in particular occupations or group together those who share a common point of view, such as those which impose a temperance or a particular religious test, the Societies comprising the great majority of the insured persons are open to receive as members any such persons without regard to residence or occupation or any similar test.

Certain Criticisms of the Society System.

205. We have received evidence criticising the Approved Society system on a variety of grounds. Our attention has been directed to the extra work in accounting, auditing and in the general supervision necessitated by the existence of nearly 8,000 separate financial and valuation units. For instance, witnesses appearing on behalf of the Central Departments informed us that administrative saving would be effected by reducing the number of separate units (see *Kinnear*, Q. 638-643 and *Leishman* Q. 1790-1791). Again Mr. Middleton, the Acting Chief Auditor, in replying to a question as to the work falling upon the auditors, said : " The fewer the units the less work, because every unit entails a kind of a nucleus or irreducible minimum of routine which could be absolutely dispensed with if its real transactions were merged into the transactions of another existing unit." " We might put it that 20 separate units of 250 members each would occupy two men for 30 days : that gives 60 man-days. A 5,000 membership group would occupy the two men for about 12 days : that gives us 24 man-days as against 60." (Q. 23,256, 23,259).

206. These criticisms relate, of course, to the cost of central administration which is not borne by the insured persons. As regards the cost to the insured members themselves, Mr. Alban Gordon expressed the view (App. XIII, 6) that " economically the excessive number of small Societies with their multiplication of establishment charges cannot fail to be an expensive method of administration." On the other hand we have no evidence that larger Societies are administered at a lower expense per head to their members than smaller Societies. The primary point in this connexion is not the size of the Society but its constitution and the agencies through which, under that constitution, its operations are conducted. Regulations fix the maximum amount per head that may be spent on expenses of administration, and so far as savings within this limit provide a criterion of relative cost, the general body of small Societies

and branches does not show to disadvantage. In this connexion we may refer to the evidence of Sir Walter Kinnear in reply to Q. 743-746.

207. Closely allied to the criticism that the Approved Society system is unduly costly in administration—indeed one of the causes for this alleged expensiveness—is the overlapping of effort for which Societies are frequently condemned arising by reason of the fact that Approved Societies may carry on business in any part of the country. In any moderate-sized town the insured persons may be scattered amongst some hundreds of Societies and branches, each of which has to make arrangements for the administration of the cash benefits to members entitled to them. For example, we were informed that in Liverpool 488 Societies have members—in Bolton 285, in Brighton 304, in Norwich 213, in Reading 245, and in Tynemouth 168 (*Kinnear*, Q. 522).

208. Again, Mr. Alban Gordon says (App. XIII, 7) : " If any area is analysed it will be found to contain a large number of Societies possessing a ludicrously small membership in that district. For example, in Dundee (which is an illustration chosen at random) there are 217 separate Societies (ignoring branches), of which 99 have less than 10 members in the town, 52 of these having only one member. These Societies have their Head Offices at London, Manchester, Glasgow, Aberdeen, Edinburgh, Leeds, Portsmouth, Newcastle, Tunbridge Wells, etc."

209. The Scottish Miners' Federation Approved Society, in referring to the fact that there are 98 Societies, each with only one member resident in Glasgow, say that " were the Glasgow area treated as a single unit in preference to having approved units studded all over like a cluster of nebulæ it would be possible to administer the area at an enormous economic saving to the insured population " (App. X, 13). It should be remembered in connexion with this allegation of overlapping and diffusion of effort that even where a Society may initially recruit members only within a limited area, these members may later become scattered; further, that in the case of any household comprising several insured persons, each of these may be in a different Society, and that the home may therefore require to be visited by the representatives of a number of competing organisations. Indeed in the extreme case represented by the National Amalgamated Approved Society, members of the same family, although in the same Society, may be visited by different agents, if their membership in the National Amalgamated Approved Society has been effected through the representatives of different companies interested in that organisation. The fact that the Scheme is not organised on a geographical basis adds undoubtedly to the labour involved in the administration of medical benefit, which must necessarily be conducted on a territorial basis. As the contributions on which the title to medical benefit depends are

collected through the Societies, it is necessary for information to be furnished by every Society to each Insurance Committee of all members of the Society in the area of the Committee at any time. The keeping of the "index register," which constitutes in fact the chief occupation of the staffs of Insurance Committees, is obviously a more considerable task than it would be if the whole Scheme were locally administered.

210. We do not regard this criticism with indifference, since it goes to the root of the question whether the present organisation of the system should be continued. We think, however, that its importance may be easily over-estimated. The chief criterion of the feature against which it is directed must be its effect upon the insured person. On this we have received no evidence that the insured person who has migrated from one district to another suffers delay in the receipt of benefit, or other inconvenience, from the fact that the office, or the head office, as the case may be, of his Society is not in the area in which he resides. It may be, indeed, that in this respect the existence of large Centralised Societies, with offices and representatives in every industrial centre in the country, is a positive advantage, since the member of such a Society is sure of the means by which his needs may be attended to wherever he may be. In any case, the insured person who suffers inconvenience has the remedy in his own hands, since he may transfer to a Society of his choice; and lest it should be urged that, in existing circumstances, some disability is attendant on transfer, we would add that in Chapter XIII we propose means for reducing such disability to a minimum.

211. Another ground on which the Approved Society system has been much criticised is that, notwithstanding the statutory requirement that every Society should be under the absolute control of its members, such control does not in fact exist and that, particularly in some of the larger Societies, the insured members have no effective means of exercising any influence in the government of the Society. The examination of Sir Thomas Neill, Chairman of the Executive Committee of the National Conference of Industrial Assurance Approved Societies, brought out in a striking manner the force of this criticism. (Q. 4515-4529, 4568-4743.)

212. It is doubtless true that, even in the case of those Societies to which this criticism is most applicable, the rules provide in theory a means whereby the insured members could have a share in the control of the Society if they cared to exercise it. Whatever may have happened to the substance, the semblance of self-government is at least respected. Even so, however, we were informed by an official witness that "in the light of experience we do not think that the rules of a few large Centralised Societies provide for the control by the members to

the extent to which the rules ought to provide. It is a very difficult question, because a very large proportion of insured members do not take any interest in the management of their Approved Societies " (*Kinnear*, Q. 23,571). At this stage it may be sufficient to quote further the view of the National Association of Trade Union Approved Societies, that as a condition of continued approval a Society " should give reasonable opportunities to its members to exercise some influence in its control and management " (Q. 21,837).

213. We have also received evidence suggesting the unsuitability of Societies, and especially the smaller Societies and branches, as agencies for the administration of any benefits in the nature of treatment. Under the Act as it stands, every Society and branch, however small, can provide for its members an additional treatment benefit within the limits of the amount allocated for the purpose out of its own disposable surplus. In the case of a Society or branch with a membership of about 100 the sum available each year under the allocation would not ordinarily exceed a few pounds, the whole of which might be exhausted in the first two or three claims for benefit which had to be dealt with. In consequence, in the not improbable event of the number of members desiring the benefit in any year being greater than the anticipated average, later claimants would be unable to obtain any benefit.

214. In the case of additional benefits, other than the increases of the normal cash benefits, it is also contended that the smaller Societies, in particular, are handicapped by the difficulties under which they inevitably labour in seeking to institute the necessary arrangements on behalf of their members. The peculiar character of these benefits has already been commented upon, and while it is true that they do not, in strictness, assume the form of treatment, but are rather payments towards the cost of treatment, nevertheless the work to be performed by Societies in their administration may involve the organisation of arrangements under which their members may receive treatment. For such work as this the small isolated Society or branch is, it is contended, obviously unsuited. To this consideration may doubtless be ascribed the fact that organisations such as the National Insurance Beneficent Society have been evolved to afford aid to Societies in such matters.

215. A further ground on which the Approved Society system was criticised was that it " stands in the way of the unification of social insurance which so many people now desire " (*Cohen*, Q. 19,892). In support of this, appeal was made to the fact that the Societies had not been considered to be suitable bodies for the administration of Unemployment Insurance or of the newly-introduced scheme of insurance for Widows', Orphans and Old Age Pensions. In this connexion we may also refer to the

evidence of Mr. Alban Gordon to the effect that " the present Approved Society system is not suitable for administering any other form of insurance benefit, nor does it seem capable of being co-ordinated with any other system of administration." (App. XIII, 19.)

216. We cannot say that criticisms of this kind commend themselves to our judgment. We have not been asked to consider the unification of social insurance, and while we cannot regard it as a practicable or desirable development merely because " so many people now desire " it, we equally cannot assume, in the absence of evidence directed to the point, that if it were introduced, no place in its administration could be found for the Approved Societies. If there are grounds for concluding that the Approved Society system is well adapted to administer the benefits of National Health Insurance, it does not appear to us that the Societies should be dispossessed from this work because some other forms of organisation are better fitted to administer other branches of social activity. The assumption implied in these criticisms that one form of organisation could equally well administer these diverse schemes of social welfare, appears to us to take for granted much that should be investigated before an opinion is formed.

217. In this rapid survey of the main lines of criticism directed against the Approved Society system, room should perhaps be found for a passing reference to one suggested element of weakness arising from the conditions under which the Insurance Scheme came into being. We have already referred to the three main types of Approved Societies—the Friendly Societies, the Trade Unions, and the Societies formed by Industrial Assurance Companies. In essence, the criticism based on the diversity of bodies engaged in the work of Health Insurance is that each of these types of organisation approached the matter with a previous history, in which its affections had already been bestowed elsewhere. Health Insurance was added to other work already undertaken; " Approved Society work was a supplementary and subsidiary activity " (*Cohen*, App. LXXVI, 27). It is suggested that the growing absorption in the work of National Health Insurance has in no way effected a change of heart or undermined the earlier and deeper loyalty. " Industrial Insurance Societies are much more concerned with canvassing for burial insurance. . . . To the good Trade Union official what matters are questions of wages, hours, workers' control and political representation " (*Cohen*, App. LXXVI, 27). In quoting Mr. Cohen's examples we do not necessarily adopt them.

The Inequalities of Benefit.

218. The main criticism of the present system is, however, directed against the inequalities which it has produced in the

benefits to which members of different Societies are entitled, and it is contended that these inequalities are too great to be defensible in a State scheme of insurance based on compulsory contributions at a uniform rate. This result has been claimed, however, by others as an advantage of the system, in that it enables the insured to group themselves in such a way as to secure the maximum advantage from their contributions and so to neutralise whatever inequity would result from the application of a flat-rate contribution to all insured persons, regardless of the variations in their several risks as affected by occupation or environment, or in their economic condition either as classes or individuals. The Act contemplated the free formation of Societies empowered to recruit their membership on any basis they might see fit to adopt. In the result a considerable process of segregation took place, so that there are few Societies which can be regarded as being in any way microcosms of the insured population as a whole. Those which are predominantly built up on an occupational basis must inevitably reflect the health risks of the trade concerned; those whose membership is predominantly centred in certain areas must be affected by the relative healthiness or unhealthiness of the districts in which the bulk of their members are to be found. And it follows by an extension of the same reasoning, that even when a Society ostensibly opens its membership to all without distinction, it may be far from representing a fair sample of the population taken as a whole. Such a Society may be stronger in one part of the country than in another; even if its membership be spread over the whole country, it may not be uniformly strong as between urban and rural areas, or as between manual and non-manual workers. As a consequence the Approved Society system is made up of Societies resting on a segregation, conscious or unconscious, of members of varying health experience and health prospects. And as the criticism is most pointedly put, the system is accused of giving additional benefits both in cash and kind to those who having the best health experience require these things least, while withholding them from those whose needs have been shown to be sorest. The Scottish Miners' Federation, for instance, say that "no one marvels at the volume of pardonable misunderstanding and personal resentment of the insured person regarding the provision of additional benefits. He never can grasp the justice of an arrangement that gives 15*s*. worth of sickness benefit a week in one Society and 20*s*. a week in some other Society for the flat contribution of 10*d*. a week. . . . He regards the question as incapable of intelligent explanation and despairingly concludes that these disparities are nothing more or less than the product of an invisible evil genius entertainingly piling up an insoluble insurance puzzle" (App. X, 14). Mr. Alban Gordon states that "it is against the public interest that a member of Society A should receive far greater

benefits than his next-door neighbour who pays the same contribution but is unfortunate enough to be a member of Society B, which gives little or no additional benefits. Grave and increasing discontent will be caused if this distinction is continued or intensified " (App. XIII, 24).

Evidence of Efficiency.

219. As against these criticisms we have, however, received a large body of evidence in support of the advantages claimed to be inherent in the present system and in favour of its retention. It was represented to us that the Societies are carrying out their work with a very fair standard of efficiency, that the contributions are being collected and the benefits administered in a satisfactory manner, and that there is no evidence of any considerable volume of opinion antagonistic to the system as such on the part of insured persons (*Kinnear*, Q. 23,543-23,546; *Leishman*, Q. 24,346). It was also urged that the present arrangement, under which every Society stands to gain or lose as the result of its own experience and standard of administration, conduces to careful supervision of claims and tends to economy and avoidance of over-expenditure on benefits (*Ancient Order of Foresters*, App. V, 24; *National Conference of Industrial Assurance Approved Societies*, App. VI, 25). Further, it was stated with much truth that the variety of types of Societies and the freedom of the insured person to choose among them are particularly well suited to the administration of a Scheme affecting many millions of the community of all types and classes and supported by a flat rate of contribution.

Continuation of the System Recommended.

220. We come, therefore, to the question whether the Approved Society system should be continued. This question must be examined from two points of view. The first is that of the maintenance of a system under which the Scheme is administered by self-governing organisations responsible for their own finance, and all that this implies in regard to additional benefits; or its supersession by a centralised system with a common fund, the benefits being administered, possibly, by local agencies but subject to close control and direction from the central governing body. The second point of view is that of the criticisms which have been directed against the methods and procedure of the Approved Societies as such, and the possibility that if these criticisms are so weighty as to indicate the desirability of abolishing the Societies, some other form of organisation, short of complete centralisation, can be found to take their place.

221. To the first of these problems we have given careful thought. We feel that if a centralised system were adopted it would compel the dissolution of the Approved Societies, since the reduction of the Societies to mere paying agencies would

involve the separation of administrative and financial responsibility, a result which could not, in our opinion, be defended. This is a serious consideration and one involving more than a mere change of method in the administration of the Health Insurance system. We feel that it is to the public advantage that this great Scheme should be administered by the representatives of the insured persons themselves, and that the governing bodies should have that full responsibility for the results of their own activities without which it is as hopeless as it would be unreasonable to look for a high standard of efficiency and vigilance. In this connexion we realise that there are features of the system which must appear to many as defects, and that these cannot be eradicated from it. On the other hand we cannot disregard the consideration that opinion as to faults and defects in a Scheme of this kind is largely a matter of the individual standpoint, and that what amounts in the eyes of some to a flaw will commend itself to others as an element of equity and justice. It is clear that if effect is to be given to the views of one school of thought, acute dissatisfaction will be aroused in the minds of those who hold the contrary opinion and regard the present machinery as equitable in its operation. We do not ourselves think that the best interests either of the State or of the insured population would be served by a vast amalgamation of all the resources of the Scheme in a common fund administered from the centre, and for the reason given we are satisfied that such an amalgamation would create as much discontent as it would allay. From this point of view, therefore, we have come to the conclusion that a system of self-governing bodies is to be preferred and should be retained.

222. As to the other type of criticisms, the substantive plea behind which is that the system of administration through the Approved Societies is open to so many objections that some new method of administration should be substituted for it, we have to take note of the fact that the Approved Societies are in possession of the field, by the action of Parliament, that they have their organisations widely distributed over the whole of the country and their staffs trained in the details of what, in many respects, is an intricate piece of social administration. The onus of showing that the system, either from causes inherent in itself, or from personal shortcomings of those by whom it is operated, works so imperfectly that it ought to be abolished, rests upon those who take this view. We have considered their evidence with care, and, we trust, without bias. We have also reviewed the evidence given to us by the large number of officials who have appeared before us as representing the Societies, and we have studied their attitude of mind in their relations with the insured person and their work generally as revealed to us by the answers given to the many questions which we have put to them. In the result we have come to the

conclusion that no case for the abolition of the Societies can be established on the broad ground of defects and shortcomings in administration. In saying this we are not to be understood as indicating that there are no faults to be remedied. We could wish, for instance, that in some quarters the interests of the insured persons were more fully considered in regard to such matters as expenditure on administration within the prescribed limit or that the rights of the members had been more fully respected when the constitutions of certain of the Societies were framed; and we have had occasional evidence, which must be treated with respect, pointing to shortcomings in the payment of benefits and other dealings between the Societies and their members. But we realise that defects of these kinds spring less from improper motives than from those human weaknesses that in some form or another must reveal themselves in whatever type of organisation may be erected to administer a great scheme such as the one we have under review; and we cannot accept them as amounting, in the whole, to the establishment of such a case against the Societies as to warrant us in recommending that they should be superseded.

It has also seemed to us in the course of our investigation that certain of the Societies may be so large as to make it impossible for the highest degree of administrative efficiency to be attained, regard being had to the limits of human capacity to deal with an intricate piece of administration of which the subjects are not mechanical but human beings with all their idiosyncrasies and weaknesses. In regard to such of these matters as seem to us capable of improvement we make appropriate recommendations. Taking everything into consideration, however, we conclude that the Approved Societies should be retained as an essential part of the system and on this fundamental question we submit a recommendation to that effect.

223. It must be clearly understood that our recommendation is made in relation to the Scheme of National Health Insurance as it exists at present, and that our view in favour of the retention of Approved Societies does not necessarily imply that developments in the system of social insurance outside the range of present contemplation might not necessitate a reconsideration of the position.

224. In disposing of this subject we think it well to refer to the existence of the considerable number of "Associations," "Conferences" and "Joint Committees" into which the Societies, which means primarily their official elements, have been banded in connexion with their work under the Acts. For the interchange of views as to the best methods of administration with due regard to the interests of the Societies and of the insured persons individually, these groupings should afford admirable opportunity and should be of corresponding value; but we are

not satisfied that this is always their primary purpose and that it is not sometimes subordinated to other objects of a less commendable character. We do not think it necessary to the welfare of the system of National Health Insurance that it should have what may, without offence, be termed a political side. To the activities engendered by such action a disproportionate part of the time of those concerned may possibly be devoted, and this must, we think, be detrimental to those important duties of daily routine in the management of the Societies which should be the first care of their paid officials. We think there is some danger to the system in tendencies of this kind, and that this may be stimulated by the arrangements under which Societies have a considerable degree of liberty in sending representatives to conferences of all kinds and remunerating them for time as well as actual expenses. If one element in the system more than any other may be regarded as a possible danger to its future, it is, we think, this inclination towards the development of what we have called a political side.

225. Having indicated these general considerations, which we think deserve serious attention, we proceed to discuss certain modifications of the Approved Society system to which, in our opinion, effect should be given as soon as possible.

Administration of Treatment Benefits.

226. In the first place it has been submitted to us that Approved Societies are not the most suitable bodies for the administration of benefits in the nature of treatment, and that the arrangements for these benefits could be better made on a territorial basis, as is already done in the case of medical benefit. Evidence on two directly conflicting lines has been put before us on this subject. On the one hand, bodies representing the Approved Societies have urged that "all treatment benefits should continue to be administered by the Societies." (*National Conference of Friendly Societies*, App. XXVI, 29; *Loyal Order of Ancient Shepherds*, App. XLIV, 36.) On the other hand, the British Medical Association point out that the powers of Approved Societies in this respect are restricted by the Act to paying the whole or part of the cost of treatment, and that Societies are not entitled to administer the treatment benefits in the proper sense. The Association "insist that payments in respect of treatment shall be under public and not under Approved Society administration." (Q. 15,000-15,002, 15,092-15,098.)

227. Sir Walter Kinnear, giving evidence on behalf of the Ministry of Health, informed us that "the administration of schemes of treatment benefits is still largely in the experimental stage. The Societies have administered these benefits fairly well, considering the difficulties under which they work, but many of the Societies, and particularly the smaller ones, are experiencing

considerable difficulties in making the necessary arrangements for treatment benefits, and, as a result, different standards of benefit are being granted by different Societies throughout the country. Few Societies are entirely local, and, as most may have members anywhere, the provision of treatment services implies an obligation to provide the treatment in areas where the Society not infrequently has not got adequate machinery for the task. The marked increase in the amount of money devoted to treatment benefits is accentuating the necessity for the administration of these benefits being co-ordinated through one local committee in each area." (*Kinnear*, Q. 23,543.)

228. We recognise that so long as any particular forms of treatment are provided only as additional benefits by certain Societies which elect to give them, and so long as different Societies allocate widely different amounts per head of membership for the provision of any benefit, the administration must remain in the hands of the Societies, at any rate, in so far as the consideration of claims for benefit is concerned. For, under these conditions, it will be clear that there will be a varying standard as between Societies, not merely so far as concerns the scale on which they may be able to assist their members, but also in regard to the scope of the treatment in respect of which help may be granted. On the other hand, if it should be possible to eliminate completely such divergences by taking any treatment benefit out of the category of additional benefits and transforming it into a statutory benefit, the whole of the administration would, of course, pass from the hands of the Societies into those of the local bodies responsible for the administration of medical benefit. In the circumstances that confront us this is a matter for the future, but we think that even under present conditions where a treatment benefit (e.g., dental benefit), is provided only as an additional benefit, but has nevertheless in fact been so widely adopted that it has been made available for a large proportion of all the insured persons in every part of the country, it would be an advantage that the negotiations with the profession by whom the service is to be provided, so far as regards the terms and conditions of service, should, as in the case of the medical service, be undertaken by the Central Government Departments. Further, we think that the supervision of the service should rest with those Departments either directly or through the agency of the local bodies responsible for the administration of medical benefit. Such an advance to uniformity would, we think, further imply that a greater attempt should be made than in the past to secure that the same benefit shall have a more or less uniform content as between different Societies.

Minimum Membership of Approved Societies.

229. We have received in evidence various suggestions as to the desirability of requiring a minimum membership as a condition

of continued approval of Societies. While some witnesses have expressed the view that it is neither practicable nor desirable to impose any such minimum limit, others have suggested a limit varying from 500 (*Independent Order of Rechabites*, Q. 6178-6179) to 100,000 (*National Conference of Industrial Assurance Approved Societies*, Q. 4990). We have been informed that some of the defects in administration which are manifested from time to time are attributable in certain cases to smallness of membership, and in particular to the fact that it may not be possible, within the amount available for expenditure on administration, to secure the services of competent officers (*Kinnear*, Q. 537,589). On the other hand we are assured that the efficiency of a Society does not vary in direct proportion to its membership, and that there are small Societies whose administration is entirely satisfactory as well as large Societies where this is far from being the case (*Kinnear*, Q. 23,562, 23,587). We are also informed that from the point of view of actuarial soundness and financial stability, a large membership is not essential (*Kinnear*, Q. 535; *Leishman*, Q. 1892). Moreover, we feel that the present widespread system of local administration through small units has the advantage of providing a closer touch between the individual insured person and his Society, and enables a very large number (estimated to be as high as 100,000) of working men and women to gain some experience of public work and social administration, with results which cannot fail to be for the general good. It is, moreover, in the Societies of this type that the tradition of voluntary and public spirited service is often best maintained. The disappearance of this tradition could not, in our opinion, be viewed otherwise than with regret.

230. We feel, therefore, that it would be inexpedient to place any arbitrary restriction on the size of Societies without regard to the quality of their administration and their effectiveness as self-contained insurance units. At the same time we think that there should be adequate provision for dealing with Societies whose administration is deficient in any respect. This is, however, not a matter which can be confined to small Societies, and we shall return to it later in relation to Approved Societies in general.

Control by Members.

231. The next point of criticism of the Approved Society system as it now exists is that, although one of the main reasons advanced in support of the adoption of the system was that it would place the management and control of National Health Insurance business in the hands of the insured persons themselves, yet in actual practice this has not been the result, so far, at any rate, as many millions of insured persons are concerned. We have had ample evidence (*National Conference of Industrial Assurance Approved Societies*, Q. 4568-4743) that in some of the

largest Societies associated with Industrial Assurance Companies there is no effective means whereby the members could exercise control over the affairs of the Societies, whilst in many other Societies where the rules do contain provision for enabling such control to be exercised, the vast majority of members, mainly, no doubt, by reason of indifference or apathy, do not avail themselves of their opportunities and evince little or no interest in the affairs of their Societies. We, therefore, think it worth while to examine at some length this question of control by members and to consider what standard should be aimed at and could reasonably be expected.

232. The Act, as has already been indicated, makes express provision that the constitution of every Approved Society "must provide for its affairs being subject to the absolute control of its members." The Act, that is to say, insists on the opportunity of control, but even an Act of Parliament could hardly insist on this control being exercised. We cannot share the surprise which is sometimes provoked by contemplation of the apathy of insured persons in these matters. The world makes so many claims on everyone that the number of things in which any of us can be keenly interested constitutes only a small fraction of those in which, as public-spirited citizens, we ought to be interested. Though we may conspire to conceal it, the truth seems to be that those who have time to be both actively and intelligently interested in all the things that affect them, individually or as citizens, are exceptional. Nor is this peculiar to any class of the community. The placidity of a County Council election, the harmony of the necessary quorum at an ordinary shareholders' meeting, the unreasoned faith of the simple man in his Bank or his Life Assurance Company, alike bear testimony to the fact that in such matters "men are unwise and curiously planned," and that most of us are content not to be too keenly interested even in matters which may directly affect us. There can be but few who, surveying their scanty and superficial knowledge of the facts underlying current controversy, can truthfully declare that they have maintained that degree of interest in public affairs which good citizenship postulates.

233. Applying these considerations to the apathy of insured persons, the situation surely is one which, however regrettable, is not merely wholly natural, but is in fact paralleled in nearly every department of the public life of the community. To expect that the great bulk of insured persons should display an active interest in the administration of the Act is to court disappointment. To put it no higher, it is not an attractive field of study, and it is probably asking too much of insured persons to suggest that they should attend meetings to discuss, for example, the propriety of the claims for sickness benefit which some of their fellows, unknown to them personally, are making, or the intricacies of particular regulations which, for the time being, have become of special interest to the Society.

234. It is, therefore, not surprising that those who are not drawn to the older Societies by their interest in other matters should be content to leave their insurance affairs in the hands of Societies which make the minimum demands on their time and attention. Nor is there any great harm—and there may be some advantage—in the existence of such Societies, provided they are efficiently and economically managed, and that their constitution furnishes effective means for the control of the Society's affairs by the members should occasion arise. On this last point there is clearly room for improvement, and we recommend that in connexion with the general review of the rules of Societies, to which we refer later in this Chapter, any Society whose present rules are found not to provide an effective means by which the members can exercise control, if they desire to do so, should be required to amend its constitution in this respect.

235. One last point on the real social significance of self-government. The question as it arises in connexion with Health Insurance is sometimes spoken of in terms of insured persons looking after their own affairs. This is, we think, to misconceive the point. It may be doubted whether those members, whose zeal in the administration of their Societies is rooted in a desire to look after their own affairs, will in fact approach the task in the right spirit. Rather will these tend to be valetudinarians. It is truer to regard the administration of a Society as offering an opportunity for public service in the interests of others, and it is safe to say that the great bulk of those who are engaged in the administration of those Societies with older traditions behind them are not in fact consciously looking after their own affairs. They are there because they desire to find some useful work which they can do for their fellows. Democracy is a means and not an end in itself, and it is not, therefore, to be condemned for relative shortcomings, so long as it is in some measure an efficient means to that greater end for which it is designed. If it be permissible in these days to quote an eminent Victorian, it should be remembered that "the business of life is an essential part of the practical education of a people." The fact that there are other channels by which a similar training in administration and affairs may be obtained cannot, except by the intolerant, be urged as a reason for despising the contribution which voluntary Friendly Societies make to our public life. All things do not appeal to all men, and diversity of opportunity in such education cannot but enrich the Commonwealth.

Supervision of Approved Societies by the Central Departments.

236. Under the Act of 1911 Societies, when once approved, were given almost complete autonomy, and although it appeared

to be implied throughout the Act that the Minister, as representing the Central Government, was to exercise some kind of general supervision over the administration of the Scheme, this was nowhere expressly stated and the powers assigned to him under the Act were extremely limited. Before any Society could secure approval, it was required to submit its proposed rules for the sanction of the Minister, but when once those rules had been approved, it was apparently contemplated that the Society should be left to go its own way, subject to two limitations only in the way of control by the Central Department.

237. In the first place, it was required to submit its accounts for audit by auditors appointed by the Treasury, whose duty it was to see that any expenditure out of its State funds had been properly incurred in accordance with the provisions of the Act; and secondly, the power was given to the Minister to withdraw approval in the event of the Society failing to comply with any of the provisions of the Act. Outside the ordinary daily routine work of administration, it is true that the Insurance Commissioners, as they then were, exercised certain powers as the ultimate court of appeal in the case of disputes between a member and his Society. It is also true that periodically after valuation the consent of the Central Department was required to a scheme of additional benefits, or a scheme for making good a deficiency, as the case might be. But undoubtedly a perusal of the Act of 1911 conveys the impression that a minimum of control had been left with the Department concerned, and that it was intended that Societies should be masters in their own house. It was soon recognised that such powers of control as were vested in the Department were too limited, and in the Act of 1913 provision was made enabling the Insurance Commissioners to withdraw approval from a Society on account of maladministration of its affairs, where it appeared expedient in the interest of the members of the Society to do so. A further measure of control was given under the Act of 1918, which applied to officers of Approved Societies certain penal provisions of the Friendly Societies Acts providing for the infliction of penalties on individual officers of Societies guilty of negligence in carrying out their statutory duties.

238. We were informed in evidence given on behalf of the Ministry of Health (*Kinnear* 567-570, 23,496-23,516) that even with these extensions the powers of supervision vested in the Minister are insufficient to enable him to take effective steps to secure and maintain in all cases the high standard of efficiency in the administration of Societies which is considered essential, and that circumstances arise from time to time pointing to the desirability of a further strengthening of his powers of control. Bearing in mind that we are here concerned with the administration of a scheme, which is financed by contributions compulsorily collected from the insured persons and their em-

ployers and supported to a substantial extent at the cost of the taxpayer, we concur in the view that the responsible department of the Central Government must be armed with adequate powers to insist on a proper standard of administration and to take effective action where any Approved Society falls short of administrative efficiency in any respect.

239. We feel that withdrawal of approval, though an appropriate weapon for grave disorders is too drastic a remedy for minor irregularities and that, moreover, it involves a procedure which may appear somewhat too formal where great issues are not at stake. We are also informed that the application of the penal provisions of the Friendly Societies Acts, to which reference has been made above has proved ineffective by reason of the fact that it involves proceedings in a court of summary jurisdiction, a course which the Department will always hesitate to take except in extreme cases (*Kinnear* 23,496). We have carefully considered what powers might appropriately be given to the Department to enable it to deal effectively with defective methods of administration on the part of an Approved Society where the alleged defect is not of so serious a character as to warrant a charge of general maladministration. The first type of case which may be considered is that of a Society whose rules contain some provision prejudicial to the interests of the members or inconsistent with sound administration and which refuses to make the necessary amendment of its rules. There are also cases where the rules, being based on the original Act of 1911, and having undergone no subsequent amendment, cannot fail to mislead the members. We were informed that when in 1912 Societies were being granted approval at the rate of some hundreds a week, it was impossible for the examination of their rules to be undertaken with the full care and attention that was desirable and that as a result some unsatisfactory provisions were passed by inadvertence. Moreover it is to be remembered that the examination of rules in 1912 was carried through at a time when there was as yet no experience of the operation of the Act, and that the desirability of amendment may only have become apparent in the light of later events. It appears that a few Societies persist in taking advantage of this position and refuse to give effect to the suggestions which have been made by the Department for the repeal or amendment of the rules in question. And as things are at present, when rules have once been sanctioned, the Minister has no power, apart from the exercise of tactful persuasion, to secure a subsequent amendment even when later legislation may have rendered certain rules wholly inoperative.

Amendment of Rules.

240. We consider that provision should be made in the Act to empower the Minister, in any case in which the rules of a Society

do not in his view adequately provide for its proper government, or are likely to operate unfairly to the prejudice of its members, to give notice to the Society, not less than one month before a general meeting, requiring it to consider the making of an amendment to the rule to which exception is taken. We further recommend that if in any case a Society should refuse or neglect to make the required amendment, the Minister should be empowered to make an Order directing that it should be deemed to be incorporated in the rules of the Society. We recognise that this proposal may be criticised in certain quarters as an infringement of the important principle of self-government of Societies by their members. We do not in any way suggest that this principle should be abrogated or that it should be open to the Minister to override the wishes of members and alter the rules of Societies as he may think fit. In order to make this clear and to provide the necessary safeguard, we suggest that it should be open to a Society to appeal against an Order of the Minister directing an amendment in its rules, and that the Society's objections should be heard and decided by some independent tribunal.

The Disputes Procedure.

241. As an illustration of the type of rule to which the suggested procedure might have to be applied, we may refer to the rules relating to the settlement of disputes between Societies and their members. We were informed that the Model Rule on this subject issued by the Department has been adopted by over 800 Societies, or more than four-fifths of the total number (*Kinnear*, Q. 23,750). This rule provides for disputes being referred to one tribunal only, before reference to the Minister, who is the final court of appeal under the Act. We were told, however, that the rules of many Societies dealing with this matter are still unsatisfactory. In England 13 Societies require appeals to be referred to two tribunals before reference to the Minister and 10 other Societies interpose three tribunals. There is, moreover, considerable variation in the time limits imposed by rule prescribing the period within which an aggrieved member is required to lodge an appeal, and in some of these there is reason to believe that the time limit operates harshly. In some cases onerous deposits varying in amount from 5*s*. to 35*s*. are required from members before their appeals can be heard. We are of opinion that in the case of centralised Societies there should be only one tribunal within the Society for the hearing of appeals before reference to the Minister, and that in the case of a Society with branches not more than two such tribunals should be allowed, first, the branch tribunal, and, secondly, a tribunal of the District to which the branch is attached, or of the central body of the Society.

Inquiry into Administration.

242. We come now to the question of conferring on the Central Departments power to deal with cases of defective administration on the part of Approved Societies where the defects alleged are not of such a grave character as to amount to general maladministration and could not, therefore, be appropriately dealt with under the provisions relating to withdrawal of approval. In these circumstances we consider that the Department should be empowered at any time to hold an inquiry into the methods of administration of a Society where there is a *prima facie* reason for believing that the administration is deficient in any respect. If, as the result of such an inquiry it is established that the standard of administration of the Society is unsatisfactory, the Minister should be authorised to require the Society to introduce such reforms as may be necessary, and if, after due warning has been given to the Society, reform is not effected, the Minister should be empowered to order such a reduction as he may think fit in the amount which the Society may be allowed to appropriate towards the cost of its administration. Inasmuch as the normal administration allowance is fixed in relation to a proper standard of administration, we consider it to be entirely proper that the rate should be reduced where the administration falls short of that standard. We further recommend that if, notwithstanding the imposition of the suggested penalty in the form of a reduction of the administration allowance, a Society still refuses or is unable to bring its administration up to a proper standard of efficiency, the case should be treated as one of maladministration justifying recourse to the procedure for withdrawal of approval.

Control of Expenditure.

243. The next point in which we consider that the powers of the Central Departments require to be strengthened is to be found in the method of dealing with improper expenditure by Approved Societies. All expenditure by Societies and Insurance Committees out of National Health Insurance funds is subject to audit by auditors appointed by the Treasury. There is, however, this important distinction, that whereas in the case of Insurance Committees the auditor has power to disallow and surcharge any item of expenditure which he considers to be improper, or not in accordance with the provisions of the Act and Regulations, he is not vested with this power in relation to the audit of Approved Societies' accounts and can only deal with cases of improper expenditure by way of a reservation in his report on those accounts. Any such reservation is brought to the notice of the Central Department who communicate on the matter with the Society concerned in order to secure, if such a course is reasonable or practicable, the repayment into the

the Society's State Insurance funds of the amount improperly expended, or, at any rate, in the hope of obtaining an adequate assurance from the Society that the improper expenditure in question will not be allowed to recur. We were told in evidence by a witness representing the Ministry of Health (*Kinnear*, Q. 23,496), that under the present procedure it is possible to dispose satisfactorily of the great majority of instances of improper expenditure by Societies, but that cases occasionally arise in which a Society declines to deal with the matter in the manner which the Department thinks proper, or to give any assurance that the improper expenditure will not be repeated. We questioned the Acting Chief Auditor of the National Insurance Audit Department as to the differentiation of treatment accorded to Approved Societies and Insurance Committees in the matter of improper expenditure, and he sought to justify this differentiation. He said : " When we disallow and surcharge in the case of Insurance Committees we have to allege negligence or misconduct on the part of the people who are being surcharged. When we consider how Approved Society expenditure is actually incurred we should find that the secretary of the group is normally a man wielding a fairly wide general executive power, in many cases merely having his action ratified at a later time. That would involve, I think, the almost inevitable surcharging of him in practically every case of improper Approved Society expenditure, and that would be an impossible position." (*Middleton*, Q. 23,265.) We cannot admit the logic of this distinction. The State Insurance Funds of Approved Societies are statutory funds held in trust by the Society for the benefit of its members, and may be used only in accordance with the provisions of the Act, and we feel that where funds of this character are in question the audit provisions are not complete unless they include the power of disallowance and surcharge. We were informed that it had only been necessary to apply this power to a very small number of disallowances in Insurance Committees' accounts, and we anticipate that it will not be otherwise if the power is extended to cover Approved Societies. None the less, we feel that it will be an effective and necessary weapon, to be used in the few extreme cases which cannot be dealt with satisfactorily without it and that its existence in the armoury may even be beneficial apart from the use that may be made of it.

244. We, therefore, recommend that the auditors of the National Insurance Audit Department should be given the power of disallowance and surcharge in the case of improper expenditure by Approved Societies, and that, as in the case of Insurance Committees, this power should be accompanied by power to the Minister to remit any surcharge, or to recover any overpayment as he may think proper in the circumstances of any particular case.

CHAPTER IX.

INEQUALITIES OF BENEFIT IN DIFFERENT APPROVED SOCIETIES.

245. We now come to the main ground on which the Approved Society system, as it now exists, has been attacked by many of the witnesses who gave evidence on the subject, namely, the serious inequalities of benefit to which the system gives rise. It has already been explained that under the scheme laid down in 1911, and continued to the present date, each Approved Society is a separate financial unit, controlling its own funds and standing to gain or lose as the result of its own experience. Any surplus found in the funds of a Society on valuation can be used solely for the benefit of the members of that Society. Although the Act provides for a flat rate of contribution from members of all Societies, there has been a wide variation in the amounts of the surpluses in different Societies on valuation. As a result of the first valuation as at the end of 1918, some Societies were still unable to give anything more than the normal statutory benefits, while others had sufficiently large surpluses to enable them to provide their members not only with substantial increases of the normal cash benefits but also with valuable additional benefits in the nature of treatment. The results of the second valuation are not yet completely available, but it is clear that the divergences will be even greater than on the occasion of the first valuation; for while it has already been found that some Societies will still be unable to provide more than the normal statutory benefits, in the more fortunate Societies the surplus on the second valuation is being found to be about three times as large as that which they enjoyed on the first. We are not surprised that these great disparities should have occasioned disappointment and dissatisfaction in certain quarters, and that they should have provoked keen criticism of the present system.

246. It will be useful at this point to illustrate by actual figures the range of divergence to which we refer. In Appendix A of the Report of the Government Actuary on the First Valuation (Cd. 1662) is given a complete statement of the surpluses and deficiencies of all the Societies. But to measure the real extent of the disparities we must find the results reduced in some form to a rate per unit of membership. For this we may refer to Table X of the same Report. We may also refer to a table and diagrams which we asked Sir Walter Kinnear (Q. 813-8) to prepare for our use. We should explain that a "unit" in these diagrams is the equivalent of a combined addition of 1*s*. to the weekly rate of sickness benefit, 6*d*. to that of disablement benefit and 2*s*. to maternity benefit. It will be seen that the range of units of disposable surplus is considerable, the highest

being five times the lowest and that large blocks of insured persons are included at each stage of the range. The fact that 1,880,630 insured persons failed to participate in any surplus at all while more than one-third of that number were entitled to the full five units is worthy of note; we think that the diagrams referred to furnish the most graphic exposition of the financial results of segregation under the present system.

Causes of Surplus.

247. The emergence of a surplus on valuation is due to a great variety of causes, some within and others outside the control of the Society. We propose here, however, to refer only to those two possible causes which were most frequently mentioned in evidence before us. The first is the segregation within a Society of lives much above or much below the general average as regards liability to sickness. For example, a Society composed mainly of rural workers could hardly fail to show a much more favourable result on valuation than a Society composed mainly of chemical workers. The second cause of surplus which was constantly quoted in evidence was careful administration, particularly as regards the supervision of claims for benefit. Undoubtedly, good administration must be a contributing cause to a satisfactory valuation result, even if it is thought that when compared with the other cause to which we have referred, it has been but a minor factor. We should like to make it clear that in advancing this proposition we are in no way lending our support to any suggestion that good administration is relatively unimportant. But we are inclined to think that, even if it were possible hypothetically to assume a uniform standard of administration throughout all Societies, the discrepancies which would have resulted would have been almost as great as those which have in fact emerged, and we are strengthened in this view by the consideration that there are prosperous Societies in which administration is not strict and unfortunate Societies which are unfortunate despite strictness of supervision.

Results of Segregation.

248. The evidence which we have received on this matter has inclined to one or other of two extremes, each of which can be supported by arguments of some force, but neither of which, as we shall show later, commends itself to us. On the one side it has been represented that the position which has now revealed itself as the result of the first two valuations was only to be expected and was clearly foreseen and explained and defended in the most definite terms when the scheme of National Health Insurance was first before Parliament in 1911. Our attention has been called to various statements, in Parliament and elsewhere by responsible Ministers and others, containing pledges

that every Society would have complete control over its own funds, and that any advantage arising out of a favourable valuation of those funds would be confined to the members of the Society. (*See* National Conference of Friendly Societies, Q. 5358; Joint Committee of Approved Societies, Q. 8298; Prudential Approved Societies, Q. 9684; National Council of Agriculture, Q. 21,075.) In opposition to this view the extremists of the other school of thought maintain that in a national system of insurance, which derives its funds from contributions compulsorily payable by the insured and their employers, there should be uniform benefits for all. We propose to deal at some length with each of these contentions.

249. In the pursuit of our task of reviewing the whole Scheme of National Health Insurance and considering what changes are desirable with a view to making the Scheme of the greatest possible benefit to the insured community, we cannot take the view that we are limited by the necessity of adhering to any particular principles on which the Scheme was originally set up, or by any statements which were made at the time of the inception of the Scheme in explanation or in defence of the provisions contained in the original Bill. On the contrary, we hold that the National Health Insurance Scheme was in the nature of a great and novel experiment in the field of social welfare, and that it must now be open to Parliament, untrammelled and unfettered, to review the whole Scheme in the light of 13 years' experience of its working and to make such changes, however drastic, as that experience may have shown to be desirable.

250. As regards the other school of thought, that, namely, which holds that in a national scheme of compulsory insurance, with uniform contributions, benefits should be payable to all on a uniform basis, we think, in the first place, that this would be incompatible with administration through Approved Societies, whether such Societies were organised as at present or on some other basis, e.g., territorial or occupational. In any sound system of insurance finance it is obvious that the power to admit claims on the fund cannot be bestowed where there is no responsibility for the solvency of that fund. A uniform rate of benefit to all insured persons implies a single fund, and it would be administratively and financially indefensible to contemplate such a fund being operated upon by independent bodies freed from the responsibility for the consequences of their actions. Several witnesses who advocated the equalisation of benefits put forward as an argument that without it the Scheme could not properly be described as " national." The word " national " is, perhaps, one to be avoided where precision of thought is desired, as the meaning attached to it is not itself precise. The mere fact that the Act of 1911 was entitled the " National Insurance Act " does not,

we think, entitle critics of the existing Scheme to contend that it should contain these features which, as some consider, the word " national " connotes. On a consideration of the word " national," as ordinarily used in countless expressions (such as the National Debt, the National Forces and similar phrases), it is obvious that whatever the word may mean, it does not necessarily imply equality either of enjoyment or of burden as between the various individuals within the nation. The merest glance at the provisions of the Act suffices to show that whatever theories inspired the framers of the Act of 1911, they did not intend to establish a scheme of that comprehensiveness and uniformity which it is sometimes suggested a national scheme should show. In the first place, the Scheme by no means included the whole population; secondly, and more particularly at the outset, there was a large measure of differentiation between the treatment accorded to the different classes who were brought within the Scheme; thirdly, without descending into the turbid and acrimonious disputes of 1911, it is clear, alike from the provisions of the Act and the debates on the Bill, that it was contemplated that different rates of benefit would emerge. Despite the title of the Act of 1911, that Act did not set up and was not designed to set up a " national scheme " in the sense sometimes attributed to that phrase. In the description of the Act, which is more important than its short title, it is properly referred to as " an Act to provide for insurance against loss of health and for the prevention and cure of sickness," but there is no *a priori* reason why an Act to promote these ends should in the common phrase " treat all alike," in the sense of guaranteeing a uniform rate of benefit for a uniform rate of contribution. In any event, the scheme of Health Insurance contemplated in 1911 was only a national scheme in the sense that the State undertook to enforce the payment of contributions in respect of those to whom the Act applied. It was thus a State scheme which relied for its fulfilment on voluntary effort, and which in intention was careful to make the utmost use of voluntary and competing organisations already in the field. On a survey of the present position it may appear to some arguable that a different scheme should be established now, but it is not, we think, permissible to base such an argument on a supposed conflict between the " national " promise of 1911, and the subsequent failure to realise these earlier ideals.

The Suggestion of Territorial Societies.

251. Several witnesses suggested, as a solution of the inequalities arising under the Approved Society system in its present form, that it should be replaced by a system of Societies on a territorial basis as, for example, by forming a Society in each County and County Borough in which all insured persons resident in the area would be included (*Gordon*, App. XIII, 20; Q. 7502). Such

a system might have some advantage over the present system, but we fail to see how it could be expected to solve the particular problem with which we are here dealing. Under the present system an insured person is free to choose the Society to which he shall belong, and if he selects a Society which proves to be relatively unsuccessful and, as a consequence, unable to provide substantial additional benefits, he is, to some extent, responsible for the unfortunate position in which he finds himself. If, however, Societies were organised on a territorial basis and every insured person were compelled to belong to a particular Society determined solely by his place of residence, it would be far less easy to justify the position arising as a result of the more favourable experience of some Societies than of others. Nor can there be any question that such a position would arise, as the difference of experience between, say, the County Society for Durham and the County Society for Dorsetshire would be substantially the same as that between a society for miners and one for rural workers.

252. Our conclusion that a system of Territorial Societies would not avoid the disadvantage of widely different financial results on valuation receives illustration in the table printed as Part X of Appendix A to the Report of the Government Actuary on the first Valuation (Cmd. 1662). In that table is shown a summary of the results of local societies and branches in England, grouped under the counties in which their offices are situated. (The large centralised societies are not included, but the table covers nearly four million insured persons.) The average net surplus per member is 24*s*. From this average there are variations as high as 39*s*. 1*d*. in Sussex, and as low as 5*s*. 1*d*. in Northumberland and Durham. The experience of all the separate counties shows that no uniformity of results is to be expected from a system of Territorial Societies.

Justification for Variations in Benefits.

253. After the most careful consideration of the subject we have come to the conclusion that with a flat rate of contribution from all insured persons, whatever their liability to sickness, the provision of varying benefits can be justified. We are impressed by the fact that the inequality of experience between different Societies is accompanied by a considerable inequality in wages. For example, agricultural workers who receive lower wages than the average artisans show better results under National Health Insurance. It was mainly on the ground that agricultural workers are on the whole less liable to sickness than persons engaged in other occupations that a demand was made on their behalf in 1911 for a lower rate of contribution and it was chiefly on the ground of the administrative difficulties of differentiation in the rate of contribution that this demand was resisted. At the same time it was

pointed out that by grouping themselves in special Societies agricultural workers would be able substantially to attain the same ends, as they would thereby reap the advantages of their light sickness experience in additional benefits which might take the form of return of contributions. It is perhaps worthy of notice that the claims of the agricultural population to be conceded a reduced rate of contribution have again been put forward. Thus, the National Farmers' Union of Scotland contend (App. LXXI; Q. 19,172-19,399) that the rate of contribution is, in the case of agricultural workers, more than sufficient to meet the cost of the benefits of that class, and that a variable rate of contribution based on sickness risks should be instituted. They point out that in the case of Societies consisting preponderantly of members residing in urban districts the contribution is only sufficient to support the normal benefits, whereas purely agricultural Societies show large surpluses. They state that " Agriculture is a healthy industry and stands apart from all other industries in this country. In all other respects it is treated separately. For instance, it is not included under the Unemployment Insurance Scheme, nor is it included in any projected legislation in regard to limitation of working hours. It makes a distinct claim for separate treatment in this connexion ". They go on to urge that " in regard to agricultural workers there should be a reduction all round in the contributions payable." The National Council of Agriculture for England state (App. LXXXV, 5; Q. 21196-21217) that the agricultural worker on the average receives a low rate of wages, and is probably content to receive a low wage partly because his occupation is a healthy one. They contend that persons in more arduous and more hazardous occupations receive higher rates of wages and should " with that high wage pay more for their Health Insurance than the agricultural worker."

254. Another justification for differentiation in benefits lies in the incentive which is thereby offered to good and careful administration. We think that it would be fatal both administratively and financially if the persons charged with the responsibility for considering claims for benefit felt that there was nothing to be gained by doing their work well and thoroughly.

Scheme to Mitigate Inequalities of Benefit.

255. While we cannot support the proposal for differential contributions, we have come to the conclusion that the possibility of the existence of differences in the rate of benefits provided by different Societies should continue to be a feature of the scheme of National Health Insurance. We believe, moreover, that the inequalities which have in fact been disclosed are only such as could have been and were foreseen in 1911 by those whose technical knowledge and experience enabled them to gauge the probabilities. It is true that as a result of the War the actual

surpluses are larger and the additional benefits greater and more widely distributed than could have been anticipated : in addition the whole picture is drawn on a larger scale as the result of the increase in rates of contribution and benefit which were made after the War in view of the change in money values. What we are concerned with, however, in this connexion is the degree of divergence from the average that is shown by particular Societies, and this is quite unaffected by the circumstances mentioned. Indeed such changes as have come about since the scheme was originally framed have operated to reduce the relative inequalities. We refer in particular to the establishment of the Contingencies Fund and the Central Fund, the purpose of which was to protect the Societies in deficiency from suffering either reduction of benefits or increase of contributions. We have emphasised these considerations because the demand for some measure of pooling of surpluses is often founded—as we have shown, erroneously—upon the theory that experience has in this respect falsified the expectations entertained by the authors of the Scheme and held out by them to the public at its inception. Although, however, this theory is shown to be untenable there remains in our opinion matter for serious consideration in the large gulf which now divides the most prosperous from the least prosperous Societies as respects the standard of benefits which they are in a position to provide for their members. We have shown that on a cold analysis the inequalities that exist can be justified. But in this matter, if we may apply a much quoted judicial aphorism, it is not sufficient that justice should in fact be done; it is equally important that the public should realise that it is being done; and we are satisfied that on grounds of broad policy it is desirable that some concession should be made to the feeling, which we believe to be widely entertained, that in a universal compulsory scheme of insurance to which a substantial contribution is made from the general resources of the State some element of mutual aid should be included, by which the more fortunate sections of the insured community will be enabled to contribute out of their abundance towards the needs of those less happily placed. These considerations, taken by themselves, would incline us to view with favour the introduction of a measure of partial equalisation of benefits so limited in its operation as to preserve the incentives to sound and economical administration on which we have laid stress above, but at the same time going considerably beyond the restricted scheme of pooling which was introduced, so far as Societies actually in deficiency are concerned, by the establishment of the Central Fund; and we find that they are powerfully reinforced by the further consideration that such a measure would set free additional resources that could be applied in the provision of extended benefits which are greatly needed and which, to be effective, should be provided for the whole insured community. We accordingly adopt the principle that the surpluses

of Approved Societies should in part be pooled and we proceed to detailed proposals for giving effect to our recommendation.

256. We consider that the surplus funds which have accrued to any Society at the date when the changes which we recommend are brought into operation, together with any future interest accruing on those funds, should remain the absolute property of the Society and that the proposals for the mitigation of inequality which we put forward should be limited to surplus earned after the change of system. This would mean in practice that at each valuation after the third, the surplus carried forward from the previous valuation (including the Contingencies Fund) with its interest earnings would be exempt from the operation of the scheme we suggest. The balance of surplus would be the amount actually earned in the quinquennium, and this is the sum which we propose to treat as subject to pooling. It is difficult to make any precise estimate of its aggregate amount, since this depends partly on facts which will not be available until the second valuation is completed, and partly on the fluctuations in the claims from period to period in the future. We are advised, however, that for the purposes of examination of our proposals a sum of about £2,000,000 a year may be assumed.

257. The proportion of this surplus which should be brought into the pool would clearly have to be substantial, since otherwise the pooling scheme would be ineffective. On the other hand the proportion left with the Societies would also have to be substantial if the incentive to good administration is not to be weakened. Our conclusion, therefore, is that the proportion should be one-half, a proportion which could also be defended on the ground that one-half of the contributions out of which the surplus arises is paid not by the members themselves but by their employers. The pooling of one-half of the surplus acquired would have the same effect broadly as if the employers' contributions were carried to a central fund and one-half of all the benefits and other charges paid thereout—a plan which might with some measure of justification have been adopted from the beginning.

258. We recommend that the amount paid into the pool should be distributed among all Societies at a flat rate per head of membership. We think that this would be the only satisfactory method of distribution, since if the money were used simply to subsidise the weaker Societies, it might have the effect of raising some of them to a better position than that of some of the Societies contributing to the pool.

259. One consideration which has weighed much with us in arriving at our decision is that after the application of the small margin in the present weekly contribution, to which reference is made in Chapter VII of our Report, there is no means, apart

from an increase of contribution or of the Exchequer grant (neither of which changes, as we have previously stated, can in our opinion be contemplated as possible in the near future), by which any general extension of the present statutory benefits can be provided for all insured persons. In Chapter X we recommend that the scope of the present medical benefit should be extended to include a specialist and consultant service, and we are satisfied that under the pooling scheme suggested above it would be possible to introduce this extension at once. When it is recognised that one effect of the partial scheme of pooling which we recommend will be to enable this important extension of the benefits of National Health Insurance to be provided at once for all insured persons, much of the opposition which might otherwise have been aroused against our proposal will, we trust, be allayed.

CHAPTER X.

PROPOSALS FOR EXTENDING MEDICAL BENEFIT.

260. In Chapter V of our Report we have described in general terms the changes in the medical aspects of National Health Insurance which we regard as ultimately desirable; and on the other hand we have indicated in Chapter VI the reasons which in our opinion make wide and costly amendment undesirable and indeed impracticable in the near future. In this and the following chapters we propose to deal with various matters which we consider are of immediate practical importance, the attainment of which is, moreover, within the financial bounds which we have regarded as prescribed for us by the general circumstances of the time. It would in our opinion be regrettable if, for reasons of financial stringency, we could propose nothing beyond a series of minor amendments. But in fact we are able —without suggesting any increase in the contribution or the Exchequer grants—to propose several fundamental changes which we think will be beneficial to the insured population at large, and in addition a considerable number of amendments, not individually of great importance, but in their cumulative effect conducive to a real improvement in the general working of the scheme. Questions relating to Approved Societies have already been considered in Chapters VIII and IX. With certain larger matters apart from these we deal in this and the next two chapters. A large number of other questions of varying degrees of importance, the consideration of which has been forced on us by the evidence or by our general review of the Scheme, are dealt with in Chapter XIII.

261. The first of the questions to which we now turn is that of the extension of the scope of medical benefit. In Chapter V we have indicated the nature of the evidence directed to this question, evidence which leaves in our mind no doubt that this extension should come first in any order of priority of proposals and that such an expansion should be made if or as soon as the necessary financial resources are available. It is unnecessary to traverse the ground again, but we may refer to two answers of Mr. Brock's which sum up the official attitude: "It has always been recognised that medical benefit could not continue indefinitely to be limited only to a general practitioner service." (*Brock*, Q. 23,830.) "In 1914 provision was made in the Budget and the money was voted by Parliament for the provision of specialist services, but that fell through on account of the War." (*Brock*, Q. 23,835.) Medical benefit is at present a general practitioner service; but it cannot seriously be claimed that this is a satisfactory state of affairs. It means that the medical service

given in respect of the insurance contribution stops short just where the need is greatest. In the serious and expensive cases the insured person is thrown back on his own resources or on the limited provision made by the general hospitals.

262. We feel very strongly that the completion of one, and that a highly important, element ought to take precedence over the introduction of new elements, however desirable in themselves the latter may be.

We have indicated in Chapter IX a financial method by which a generous provision of expert out-patient services can be made available without entrenching on the margin in the present contribution disclosed in Chapter VII, which margin we propose (as will be seen in Chapter XI) should be applied in another important direction. This method of providing the necessary funds has, as we consider, the additional merit that it at the same time reduces that disparity of resources between the various Societies which has evoked adverse criticism in so many quarters. But whether the cost of an extended medical benefit is met in this or in some other way, such extension should, as we have said, receive first and immediate consideration. Without it, indeed, the limitations of medical benefit remain the most obvious weakness in the whole scheme of benefits under National Health Insurance.

The Content of an Extended Medical Benefit.

263. What, then, should be the content of this extended medical benefit which is to be available for all insured persons until such time, whether near or remote, as a more comprehensive system of health service is evolved? The following should, we think, be provided in addition to the general practitioner treatment of the present contract :—

(1) Expert medical advice and treatment for patients who can travel to meet the specialist.

(2) Expert advice for persons who are unable to travel.

(3) Laboratory services.

These elements may be briefly described as " expert out-patient services "—a definition which is intended to cover all the out-patient services which specialists give as a class, including, for example, ophthalmic diagnosis and prescription of glasses.

The Problem of In-Patient Treatment in Hospitals.

264. We have not included in-patient treatment in hospitals for a variety of reasons, though that also would form part of a really complete medical service. Under present conditions we must very largely be guided by considerations of cost, and that for in-patient treatment would be very heavy, involving not

only the cost of maintenance but probably also that of medical and surgical services now given gratuitously. The Ministry of Health representative informed us that "in the view of the Ministry it would not be desirable to attempt to include institutional treatment in the Acts as a statutory benefit. To provide the whole cost of in-patient treatment of insured persons would be extremely costly, and there is the difficulty that a statutory benefit implies some guarantee that the required accommodation will be available when it is needed. So far as regards voluntary hospitals no such guarantee could possibly be given. . . . Any scheme which resulted in preference being given to a particular class, however large that class might be, must in our view be prejudicial to the voluntary system." (*Brock*, Q. 23,852.) The Scottish Board of Health, who have urged strongly that this element should be included in any immediate extension, estimate that for Scotland alone an expenditure of about £160,000 a year would be required. For the whole of Great Britain the cost would be, on that basis, about £1,500,000, which, added to the cost of the three elements we have suggested above, would far exceed the amount available if, as we propose in Chapter XI, anything is to be done in the way of improving the cash allowances in sickness and disablement. Further, the Scottish estimate is only for part (about one-quarter) of the total cost, the assumption being that private subscriptions and donations would continue to meet the balance. This, we think, is an untenable assumption. Once the insurance funds were committed to meeting part of the cost of in-patient treatment, it would be highly probable that the part would change gradually into the whole so far as insured persons were concerned, and that a liability far beyond the present estimate would ultimately be incurred. In any case we must point out that so long as the hospitals treat the insured and the uninsured on the same basis and retain, as they desire to do, complete independence in the management of their funds, it would be very difficult to justify a systematic and substantial support from the insurance scheme for this purpose. We think that the present arrangements, under which Approved Societies may give financial assistance to the hospitals under their schemes of additional benefits or by way of donations under Section 26 of the Act (with a certain modification in the latter which we recommend in Chapter XIII), may be continued, but that no general provision of hospital treatment can be at present contemplated within the Insurance Scheme. We fully appreciate the great work the hospitals are doing alike for the insured and the uninsured, and we do not underrate their financial difficulties. But both on grounds of finance and policy we accept the view of the Ministry of Health (as set out in reply to Q. 23,852) that an extension of this nature must be left over for future consideration.

265. In illustration of the way in which the small contributions of the people—insured and non-insured alike—are applied towards securing hospital treatment, we may refer to the statement submitted by the Hospital Saving Association (App. CXXX). It is there explained that for a contribution of threepence a week a large number of hospitals have agreed to relieve from any enquiry as to means, the contributor or his dependants when admitted to the hospital; and this arrangement applies equally to in- and out-patients. If the patient is treated at a hospital not on the list of the Association the contributor is reimbursed, by the Association, any normal payments which he has been called upon to make towards his maintenance for a period not exceeding ten weeks. These arrangements, which we think are in themselves wholly commendable, make apparently no distinction between the insured and the uninsured, and accordingly we are reinforced in our view that the claim of the hospitals to assistance from Health Insurance funds is not valid under present conditions and can never be so until an appropriate preference is given to insured persons either financially or by way of priority in treatment or in some other manner that definitely recognises the dual position which in such matters they clearly occupy.

266. In this connexion one further point should be noted. We have referred in Chapter V to the difficult position that would arise if, for example, hospital in-patient treatment were provided for the insured while the classes of persons just above the insurable level, to whom the cost of a major operation is a severe and often crippling burden, were given no assistance from public funds. If we were recommending as part of the extended medical benefit, the inclusion of such services either in the home or in the hospital, we should feel seriously concerned about the position of non-insured persons of moderate means. Under these circumstances, indeed, we are sure that an attempt would have to be made to find some way of making a similar benefit available to this class. We are convinced that this problem must ultimately be faced and that no large and unified scheme of health services will be entirely satisfactory unless it provides a solution. Within the limits of our present proposal, however, the difficulty does not assume the grave form which it would indubitably present if it were suggested that hospital treatment and major operations should be included within the scope of medical benefit.

Maternity and Dental Services.

267. Nor have we included maternity services and dental treatment, though these also, we hope, would find their place in any full Public Health Service of the future. In Chapter XII we deal at some length with these problems in their immediate aspects, and in particular make an important recommendation for improving the dental service given under the additional benefit

schemes. Here we need only say that our exclusion of these elements from any immediate provision of a generally available medical benefit is dictated in the main by financial considerations —though, of course, we have carefully considered from every point of view the relative claims of the various possible extensions on the available funds.

268. We conclude, then, that the extended medical benefit to be recommended for immediate adoption should add to the general practitioner service only the three elements stated in paragraph 263 above. We now proceed to describe these in detail, to indicate methods of administration, and to give estimates of the cost involved. In this connexion we direct special attention to the statement which the Ministry of Health have submitted to us in Appendix CIII, dealing with the numerous discussions of these problems between the National Health Insurance Commissioners and the medical profession and also to the examination of Mr. Brock and Dr. Smith Whitaker in Questions 23,830 to 23,846. The problem is obviously no new one, and but for the War would probably have been solved many years ago.

Provision of Expert Treatment or Advice for Persons Able to Travel.

269. The services which specialists can render to supplement or assist the work of the general practitioner include (1) advice as to diagnosis, (2) advice as to treatment which the practitioner can himself properly undertake, and (3) treatment of a kind which only a specialist can give, or for which special resources of equipment and skilled assistance such as that of masseurs or electricians, are requisite.

270. A difficult question of principle emerges at the outset Services of this kind are, to a certain extent, already available for insured persons, as for other members of the community, in the out-patient departments of hospitals. Do the services thus obtained fall short of the requirements of a satisfactory service for the whole insured population? If they do, is some scheme of supplementation of these services practicable and desirable? Or are we driven to the conclusion that the specialist out-patient service must be provided completely irrespective of what the hospitals are already doing?

271. Dr. Smith Whitaker, in answer to questions on these points, replied :—" The local authorities, whatever they were, who had to carry out the organisation would probably adopt a variety of methods, some in one place and some in another, but generally we doubt whether a system which was based on contracts with the hospitals for providing the services would work satisfactorily. The insurance authority,

whatever it might be, would be responsible for the efficiency of the service provided, and probably they would feel it was necessary that the service should be under their direct control" (Q. 23,834). "Whenever this question has been discussed, particularly when it was discussed with representatives of the Medical Profession in 1919, the greatest possible importance was attached to communication between the practitioner and the consultant with regard to the case . . . That, I think, is one of the weaknesses of the present system that you cannot secure that kind of close co-operation, and it is doubtful whether you could ever get the co-operation carried out satisfactorily unless the consultant and the practitioner were both responsible directly to the same body" (Q. 23,835). "While it would be very desirable to utilise hospital premises by renting them wherever possible, the system could not be so satisfactorily worked by entering into contracts with the hospitals to provide the service" (Q. 23,833).

Availability of Out-patient Treatment at Hospitals.

272. It appears that the extent to which specialist treatment and advice are obtained at the hospitals varies greatly in different parts of the country, and even as between different medical men practising in the same area. These variations result from :—

(1) differences in the accessibility of patients to hospitals;

(2) the different customs of different hospitals, as a whole;

(3) personal characteristics of particular members of the medical staffs of hospitals;

(4) differences in the attitude of practitioners and in their relationships to particular consultants;

(5) differences of attitude of insured persons.

273. In the large centres of population, in the neighbourhood of the great hospitals attached to medical schools, there is little difficulty in obtaining specialist treatment. Second opinions are also readily obtained in the majority of cases by those practitioners who take a not unreasonable amount of trouble to obtain them. At some of these hospitals, great pains are taken to convey to the practitioner information as to treatment which has been given, or advice as to diagnosis or treatment, even though he should have himself failed to send particulars of the case to the hospital. The position is on the whole less satisfactory in places in the immediate neighbourhood of large hospitals not attached to medical schools. In such cases the general practitioners have probably less confidence in the opinion of the staff of the hospital, which includes a considerable proportion of men who are themselves general practitioners and the former, therefore, are not so ready to seek the advice of the latter.

274. Distance from the hospital plays, obviously, a very important part in determining the extent to which insured persons

avail themselves of such facilities. Beyond this, there is a certain amount of evidence that many insured persons are reluctant to go to the out-patient departments, as a charity, while they would not hesitate to avail themselves of the same specialist services if included in medical benefit, as they would then feel that they had a full legal and moral right to receive these services when needed. Some are deterred by the crowded state of the out-patient departments and the long time they may have to wait for attention. Others are deterred by the charges made. Again, some of the insured persons whose income brings them near the limit of insurability, prefer, when specialist advice is necessary, to employ the specialist privately, thinking that in this way they will receive more careful attention than if they obtained gratuitous advice.

275. It is clear that under existing conditions many insured persons do not obtain from the out-patient departments the specialist treatment that is needed, and, in respect of those who do, the attending practitioner frequently does not obtain the second opinion on diagnosis or treatment which is desirable in the interest of his patient.

General Conditions for the New Scheme.

276. If expert out-patient services are to be provided as part of medical benefit, it is necessary, in the first place, that these services should be sufficiently accessible in all parts of the country, specialists being employed to attend at frequent intervals in central places in those districts in which there are at present no physicians or surgeons who possess the necessary qualifications. Further, travelling expenses of insured persons referred to specialists under the scheme should be defrayed as part of the service. These two provisions would not add a relatively large amount to the cost of the scheme, and would remove the present deterrent effects of distance.

277. Taking all these matters into consideration, we come to the conclusion that the new system should be built up, not by way of supplementation of the existing out-patient work of the hospitals, but as an independent scheme organised effectively throughout the whole country, providing for the closest consultation and reciprocal communication between the general practioner and the specialist, and giving the title to the service to all insured persons as part of the consideration for which they are paying their compulsory contributions.

278. Under such a scheme, there would be laid upon the insurance practitioner an obligation to refer a case for specialist advice and treatment when the circumstances rendered such a course appropriate. He would also have to furnish a statement of the history and the present condition of the patient, as known

to him, and a statement of the points on which specialist opinion is desired. Such an arrangement is already in force where cases are referred to the Regional Medical Officer or to the Tuberculosis Officer. This system has received the cordial approval of the medical profession. The obligation thus placed on the insurance practitioner would be accompanied by a similar definite obligation on the specialist. The practitioner should receive a report on any person treated by the specialist, with advice as to further treatment, and also in cases not needing specialist treatment, advice as to diagnosis or as to the treatment which the practitioner himself should carry out.

279. The provision of specialist services in this way as part of medical benefit would result in :—

(1) A substantial increase in the availability of such services.

(2) A substantial increase in the proportion of cases in which general practitioners would avail themselves of such services.

(3) A greater disposition on the part of insured persons to obtain benefit.

(4) An exchange, not as now in a proportion of cases only, but in all cases, between the practitioner and the specialist, of the information which each should have, and definite guidance for the practitioner as to both diagnosis and treatment.

Reactions on Efficiency of General Practitioners.

280. These in themselves would be great advantages, but of equal importance, in their ultimate bearing on the health of insured persons and of the community generally, are the prospective indirect effects of such a system in improving the efficiency of the general practitioner. It has been long recognised that he suffers great disadvantages in the maintenance of his professional efficiency, through the isolation experienced under present conditions of practice. A large proportion of practitioners have few opportunities for coming into contact with those who are devoting themselves to the study and practice of particular branches of medicine and surgery. Unless they have mixed practices with a fair proportion of persons of means there are few opportunities of comparing the expert's view on a case with their own. Of the real deficiencies in their methods which would be observed by a competent colleague, they are thus necessarily unaware.

281. In a system under which specialist services and general practitioner services were welded into one scheme, the conditions of general practice in this respect would be completely changed.

The mere obligation to furnish the expert with a statement of the case would have a valuable and educational influence in constraining the practitioner to give definiteness to his ideas. When he had to prepare a statement to come under the critical eye of the expert he would, by that mere fact, become alive to defects in his conduct of the case, which he had not previously realised. The indirect benefit resulting from such a requirement has, we are informed, already been seen in the work of the Regional Medical Staff. Again, the specialist's report will often reveal to the practitioner points in diagnosis or treatment which he might have overlooked. It will thus add to his knowledge by enabling him to assimilate the expert view of his cases as they come along. In all these ways the provision of a specialist service would operate as a most valuable form of post-graduate instruction and would probably be gratefully welcomed by the isolated general practitioner. The educational benefits so resulting would not be confined to the insured persons, but would be extended to the whole range of general practice.

Administrative Arrangements.

282. The administrative arrangements for this particular provision would be relatively simple and inexpensive in proportion to the total cost. They would naturally follow the present lines of administration of medical benefit, i.e., the responsibility of making local arrangements would lie with the body that takes over the work of the Insurance Committee, or possibly with a group of such bodies. Their duty would be to frame a scheme in accordance with principles laid down by the Ministry, after consultation with representatives of the medical profession, and the adoption of the scheme would be subject to the approval of the Ministry. The chief points requiring attention in each local scheme would relate to the provision for the selection of the specialists to be employed, the arrangements as to places and times at which patients should be examined and treated, the employment of ancillary staff, and the rates and methods of remuneration.

283. It should be open to any doctor possessing the requisite qualifications to take part in the work, and the decision as to whether particular doctors possess the requisite qualifications might lie in the hands of a mixed lay and medical committee, some at least of the medical members being drawn from outside the area.

284. The arrangements as to the places and times at which patients should be seen might take a variety of forms. The doctors might see the patients at their own consulting rooms; arrangements might be made with the hospitals for the work to be done in the out-patient departments, or thirdly, the local authority administering the benefit might establish the requisite

number of clinics, using hospital premises for the purpose, whenever these could be obtained. We are aware of the objections of the medical profession to a general system of clinics, even clinics under professional control, and we have always before us the importance of securing the willing co-operation of the profession at each advance in the public arrangements. We therefore think it would be undesirable at this stage to attempt a uniform system and that full opportunity should be given for composite local schemes.

285. If arrangements were made for the work to be done at the physician's or surgeon's consulting room, no question of employment of additional nurses or other ancillary staff need arise. So far as arrangements were made with hospitals, they would usually be able to provide the requisite staff, as part of the contract for the use of their premises. In so far as it might be found necessary to establish new clinical centres, nurses, masseurs and electricians would have to be employed.

Method of Remuneration of Consultants and Specialists.

286. If the work were done at the doctors' consulting rooms they would probably prefer to be paid a fee per case. It would, however, be possible, even under that arrangement, to pay on a time basis, the arrangement being that a fixed number of cases would be summoned to attend at the consulting room at a specified time, this being the number which would normally occupy about 2½ hours. A fixed fee would be paid for the session. Where treatment was given at centres at which various specialists attended, the proper method of remuneration would be on a time basis.

Estimate of Cost of Provision for Persons able to Travel.

287. The Ministry of Health have submitted to us an estimate of the cost of providing this part of the service on the basis of sessions at fixed centres at which the specialist and the insured persons would attend. The costs to be provided for include (1) the fees for physicians and surgeons, (2) payment of ancillary staff, including nurses, masseurs and electricians, (3) rent of premises, (4) travelling expenses for insured persons, (5) cost of administration.

288. The estimate has been based upon inquiries made by the Regional Medical Officers and on statistics published by certain hospitals. The conclusion of the Ministry is that for the insured population of 13½ millions in England and Wales the cost would not, on the lowest assumptions as to number of persons referred and other factors of cost, fall below £487,000, and would be unlikely to exceed £940,000 per annum. This is, of course, a wide difference. It is mainly due to different assumptions as to the proportion of the insured population that would be referred to the specialist.

Provision of Consultant Services at Patient's Home.

289. As a result of recent inquiries by the Regional Medical Officers, the Ministry have found that a large number of practitioners thought it very desirable that the services of a specialist should be available for consultation at the patient's home in the case of persons who are unfit to travel. Some of these mentioned cases of acute illnesses, such as pneumonia or "acute abdomen," as cases in which such help was specially needed.

290. Of the value of second opinions in such cases, there can be no doubt, not only on account of the assistance given to the doctor in cases in which he needs expert advice as to diagnosis, or as to the best course of treatment to adopt, but also on account of the relief thus given to the mind of the patient, or of his relatives, in cases of dangerous illness, even although the general practitioner in attendance may have no doubt as to the diagnosis or the proper course of treatment. In the cases of the latter group, however, what is wanted is not necessarily the opinion of an expert. The second opinion of any general practitioner of wide experience and good standing will usually serve the purpose equally well. Moreover, in acute illnesses of patients residing at some distance from the nearest centre at which experts are available, considerations of time may make it more advisable to get the opinion of a general practitioner, who is more quickly available. These latter considerations obviously must affect materially the estimate of cost.

291. The appropriate method of administering such a provision would be to draw up lists of approved experts and approved general practitioners in different parts of the country who might be called in when required, and to supply such lists to the practitioners concerned. In the large cities and towns, it might be possible to allow an expert to be called in wherever a second opinion was desired by the practitioner in attendance. In other places, the practitioner might be allowed to call in an expert in a case in which he thought expert advice really necessary and otherwise to call in an approved general practitioner from the neighbourhood. It would, however, probably be desirable that the proposal to call in an expert should first be submitted for approval by a medical officer appointed for the purpose (who might be one of the Regional Medical Officers of the Ministry) except where the practitioner certified that the case was one of urgency. That, however, is a matter of detail which we think should be left over for negotiation between the Ministry and the profession when the general outlines of this part of the scheme have been settled.

Estimate of Cost of Home Service.

292. On the basis of such information as is at present available the Ministry have estimated that the cost of domiciliary consultant services would probably not exceed £250,000; but

the estimate is admitted to be highly conjectural, resting mainly on the personal impression of members of the Regional Medical Staff of the Ministry who have had extensive experience of general practice.

The great difficulty of forming even an approximate estimate of the cost of these particular services arises, first, from the lack of data of the extent of the real need of them, and, secondly, from the difficulty of devising adequate safeguards against unnecessary calls for second opinions. It is obvious that without such safeguards a large cost might be incurred without corresponding advantage. For these reasons, we recommend that the working of the arrangements for the provision of a domiciliary consultant service should be closely watched by the Central Department, particularly in the early stages, to ensure that the system is not resorted to by lax or negligent practitioners in cases where no real doubt arises in regard either to diagnosis or treatment.

Laboratory Aids to Diagnosis.

293. There appears to be a unanimous and strong desire for the provision of laboratory aids to diagnosis. Under this head are included :—

(1) Microscopic, bacteriological, or chemical examination of blood, fluids aspirated or otherwise obtained from the patient, such as cerebro-spinal, pleuritic and ascitic, urine, fæces, sputum, vomit, pus, tumours and other tissues.

(2) Tests of function, i.e., urea elimination, test meal.

This list is exclusive of the examinations made for the preparation of autogenous vaccines, and of the examinations now undertaken by local authorities, i.e., examinations of diphtheria swabs, sputum for the tubercle bacillus, Widal reactions, and Wassermann reactions and other tests in connection with venereal disease.

294. If a scheme were being prepared for the provision of services for the whole population, it might be worth while to go into questions of possible organisation of a scheme of laboratories that would be newly provided where not already available. But when considering provision for insured persons only, we understand that there is no reason to suppose that contracts could not be made with existing laboratories for doing all the work.

Estimate of Cost of Laboratory Aids.

295. As to cost, we understand that the estimates obtained from general practitioners of the prospective demand for such services have varied somewhat widely, and in some of them, sufficient account does not appear to have been taken of the considerable increase in the volume of work which would probably have to be undertaken, particularly if the service were associated with the provision of specialist clinical services. The figures given converge towards about £5 per 1,000 insured per-

sons per annum. The highest figure suggested was about £10 per 1,000. The estimated cost for England and Wales may therefore be taken at about £100,000. (*Smith Whitaker*, Q. 24,013.)

General Summary of Cost.

296. Bringing together the estimates above stated under the three main heads it will be seen that the maximum annual cost of a scheme of expert out-patient services such as we have outlined, including all the work for a population of 13,500,000, is as follows :—

	£
Specialist services	940,000
Bedside consultations	250,000
Laboratory aids	100,000
Total	£1,290,000

297. These, we are informed, are outside figures in each case, and it is not probable that, even if reached eventually they are likely to be attained for some years after the commencement of the scheme. The financial aspect of the problem is summed up in Mr. Brock's answer to Q. 23,830 : " Such a service, we think, could be organised at a cost—I am putting it very roughly—of 2*s*. per head if you include provision for domiciliary attendance."

298. It should be noted that these estimates are for the insured population of England and Wales, viz., 13,500,000. We have received estimates for the corresponding Scottish problem which are in fair agreement, though somewhat lower for the same types of service. For a provision of specialist and consultant services, including institutional treatment but not including convalescent and dental treatment, the estimate of the Scottish Board of Health is from 2*s*. 9*d*. to 3*s*. per insured person per annum. (*Leishman*, Q. 24,334.)

299. In conclusion, then, we consider that an extension of medical benefit on the particular lines we have described could be provided for the whole of Great Britain, with its insured population of about 15 millions, at a cost (taking the maximum figures suggested to us) of about £1½ million a year. This is not a large sum in insurance finance. We are convinced that the results in the way of extending the scope of the medical diagnosis and treatment which the insured persons at present receive, and of spreading expert knowledge and modern methods among the general practitioners themselves, would fully justify the expenditure. As we have said, the money can be obtained by such a scheme of pooling as we have proposed. Accordingly we recommend that this addition be made available to all insured persons as an integral part of medical benefit under the Insurance Scheme.

CHAPTER XI.

PROPOSAL FOR DEPENDANTS' ALLOWANCES.

300. We now have to consider certain other proposals of a major nature which have been placed before us. We find two which in our opinion are close rivals for the second place in the order of priority in which such funds as may be available should be applied. These are an increase in the scales of sickness and disablement benefits, and a maternity benefit enlarged to include all necessary medical services. We have examined closely the evidence relating to these questions and have received estimates of cost from the Ministry of Health and the Actuarial Committee. The maternity question is dealt with in the next chapter. For reasons which will appear later we have decided to give priority in our recommendations to an extension of the cash benefits available in sickness and disablement. It is appropriate to remark here that the estimated cost of the proposal we make in this regard is practically the total sum which the margin in the present contribution makes available. Thus, if this proposal is adopted and the cost of extended medical benefit is met by the scheme of pooling of surpluses described in Chapter IX, no further extensions or modifications involving substantial expenditure can be proposed as immediately practicable within the financial limits we have set.

Evidence as to the Rates of Cash Benefit.

301. The evidence as to the sufficiency of the rates of sickness and disablement benefits has been of a varied character. This was almost inevitable in a system where sickness benefit means 15*s*. in some Societies, 20*s*. in others, and various intermediate figures elsewhere; where, too, some Approved Societies provide substantial benefits on the basis of voluntary insurance and lay great stress on the maintenance of this side of their work, while others confine themselves to the State scheme and look to its expansion for greater support of their members in time of sickness. Thus, on the one hand, the Manchester Unity of Oddfellows, though they do not suggest that the existing rates of benefit are adequate for the maintenance of a married man and his family, contend (App. VII, 67) that "the statutory rates of sickness and disablement benefit laid down in the Act should not be increased," and in reply to questions which we put to them admitted quite frankly that their recommendation was based on the apprehension that any increase in the normal rates of benefit under the Act would be likely "to have a very detrimental effect upon the voluntary thrift movement." (Q. 5921-5938). Similarly, the Independent Order of Rechabites state that they "are not

favourable to the present rates of payment for sickness and disablement benefits being increased. Voluntary Societies make ample provision for any person who requires a larger amount of benefit than is provided under National Health Insurance." (App. VIII, 5.) " We are of opinion that the present standard rates should be the maximum on the ground that the real purpose of the Act is preventive and curative, and not so much for the purpose of providing monetary benefit at the time of sickness, and that there are agencies in existence, and were in existence before the inception of the National Insurance Act, which were then, and are to-day, quite capable of providing monetary assistance if such is needed." (Q. 6107, 6128-6145, 6159-6162.) Other witnesses representing the Friendly Societies gave evidence to a similar effect (e.g., *Loyal Order of Ancient Shepherds*, App. XLIV, 18-19; Q. 14,086-14,099, and the *National Conference of Friendly Societies*, Q. 10,649-10,660).

302. On the other hand, certain witnesses refer to the inadequacy of the present rates of benefit for the purpose of meeting the requirements of a sick person and his family. For instance, the Lancashire and Cheshire Miners' Federation Approved Society point out that " when a man is sick he requires more money, not less, for the purpose of obtaining nourishment " (Q. 7381) and express the view that " if a man receives what he does for compensation because of injury received while following his employment he ought, if he is laid aside through sickness, to be paid a similar amount." (Q. 7382.)

303. The impression left on us by evidence of this type is that the present rates are not considered really adequate for maintenance in time of sickness, even by their defenders, but that they provide an assured minimum to which, as a basis, other provision, e.g. additional benefits, voluntary insurance, savings, &c., may be added, and that there are advantages, moral and otherwise, in such a mixed system.

Relation of Benefits to cost of Living.

304. It is interesting to note that when in 1920 the rates of the 1911 Act were raised by 50 per cent. to meet the increased cost of living, that cost had in fact risen at that time by about 175 per cent. No doubt the general prosperity and high wage-rates of that time made this disparity of the two increases of no great importance. Now, however, with reduced wages, much unemployment, and little opportunity for saving, the question of disparity is of considerable moment. The disparity is in fact, and fortunately, nothing like what it was. But it still remains. The cost of living is 75 per cent. higher than in 1914, the rates of benefit only 50 per cent. Even when every allowance is made for additional benefits, the comparison between the present position of the statutory cash benefits and that of 1914 cannot be regarded as entirely satisfactory.

Supplementation of Benefits from Poor Rates.

305. This consideration, it may be said, is theoretical. We have, as already indicated in Chapter IV, received some definite evidence showing that there are cases in which the resources of the Poor Law are drawn upon to supplement the cash benefits of the Health Insurance scheme. In the first place we would refer to certain figures submitted to us by the Scottish Board of Health and contained in the table at the end of Appendix CV. These show that during the last three months of the year 1924, in 40 industrial parishes in Scotland, 2,952 insured persons in receipt of Sickness or Disablement Benefit to a total value of £1,674 received also from Poor Law funds assistance to the total value of £2,123 and had further assistance from other sources to a total value of £826. It may, therefore, be presumed that in the judgment of the Parish Councils concerned the total of these three sums was necessary in the case of these insured persons as a minimum provision for the needs of life. Lest there should be any misunderstanding, we think it necessary to point out that the 2,952 insured persons to whom this supplementary assistance was given do not represent the total number of insured persons in receipt of Sickness or Disablement Benefit in the 40 parishes during the period in question. It is sufficient to inspect the names of the "parishes" concerned, which include Aberdeen, Edinburgh and Glasgow, to realise that the persons in question constituted a very insignificant minority of all insured persons who drew Sickness and Disablement Benefit in these areas.

306. In the same connexion, we may refer to the tables in paragraph 71 of Appendix CIV which show the experience in this matter of two very large Boards of Guardians. These tables also show that a certain proportion of insured persons resort to the Poor Law and are given relief in supplementation of the benefits which they are receiving under the Health Insurance Scheme. We have no reason to believe that the experience of these Boards is not typical, or that the Boards themselves are unduly generous in their administration of relief. The inference then is that in the opinion of these Boards of Guardians, as expressed in practical day by day administration affecting the rates which they levy, the cash benefits are not in themselves adequate for the bare necessities of life; and that in those cases where no further financial assistance is available from voluntary insurance through a Friendly Society or Trade Union, private thrift, or help from relatives, the Poor Law has still to play the role of residuary legatee to the poverty and distress of insured persons.

Comparison with Rates of Unemployment Benefit.

307. We cannot conclude this survey without referring to the disparity between the rates under the State Insurance

Schemes for Unemployment and Health respectively. The former rates are 18*s.* a week for a man and 15*s.* for a woman with additions of 5*s.* for the wife of an insured man and 2*s.* for each dependent child—clearly a much more generous provision than the basic rates of the Health Scheme. Here, again, the comparison is made difficult by the irregular distribution over the insured population of the additional benefits. It must also be borne in mind in any comparison between the cash benefits of the Unemployment and Health Insurance Schemes that a substantially lower rate of contribution prevails in the latter, and that, even so, that contribution provides medical as well as cash benefits. A comparison between the two Schemes must not disregard what the workers are paying for the comparable benefits. Nevertheless the fact remains that the basic rates of cash benefit under the Health Scheme which are all that a considerable proportion of the insured population are entitled to, are substantially below those for Unemployment Insurance, while the fundamental fact of cessation of wages is the same in both cases. Further the need for financial help must in general be greater in a period of ill-health than in a period of unemployment of the same duration. The existing position seems to us difficult to defend. Differences of machinery, such as the Employment Exchange system in the one case and the Approved Society system in the other, a single fund in the one and segregated funds in the other, can be justified. But here we are concerned with the actual provision made in the homes of those who are in closely similar circumstances of distress.

Alternative Forms of Increased Benefit.

308. Impressed by these considerations we have turned with the greatest sympathy to examine the possibility of increasing the cash benefits in one form or other. In this problem we naturally had again to refer to the Actuarial Committee for expert advice on the problems involved. We asked them to supply estimates for the three following proposals—(1) an increase of the rates of Sickness Benefit to those of the Unemployment Insurance Scheme with corresponding increases in Disablement Benefit; (2) an increase of Disablement Benefit only; (3) the provision of allowances for dependants on the lines of the Unemployment Insurance Scheme. The report of the Committee on these references is printed in Appendix A to this Report.

309. As we have already pointed out in Chapter VII, the margin in the present contribution after allowance is made for the medical charges is much larger in the case of men than in that of women, being in the former case such as will produce with the State grant a sum of 4*s.* per head per year, and in the latter only 9*d.* This disparity must influence very materially

the question of extensions since, if rates of contribution are to remain unchanged, any extension the charges for which fall equally on the man's and the woman's contribution must be limited by the smaller sum. Moreover, in that case a substantial margin in the man's contribution would remain unapplied. On the other hand if an extension can be planned which falls mainly on the man's contribution, difficulty is avoided. It will be seen later that this consideration among others drives us to a scheme of allowances for dependants in preference to increases in the normal rates of benefit for all insured persons.

Increase of Standard Rates of Sickness Benefit.

310. We first considered the possibility of raising the standard rates of sickness benefit for men and women respectively to the basic rates of unemployment benefit, namely, 18*s.* and 15*s.* a week respectively. We assumed that in the first two years of insurance the present reduced sickness benefit of 9*s.* and 7*s.* 6*d.* a week respectively would be retained, these being one-half of the proposed full rates. We assumed, further, that the rates of disablement benefit would be increased to 9*s.* in the case of men, thus retaining the present relation between sickness and disablement benefit for men. In the case of women, where the available margin of the contribution was relatively very small, we have for that reason assumed that disablement benefit must remain at its present figure of 7*s.* 6*d.* a week. On this basis the rate of disablement benefit would be one-half the rate of sickness benefit for each sex.

311. One disadvantage of this proposal is that the women would receive no increase in disablement benefit, which would remain less than that of men by 1*s.* 6*d.* whereas under the present arrangement both sexes receive the same rate. But there is a larger difficulty on financial grounds. From the report of the Actuarial Committee it will be seen that the contribution required for this scheme would be 9·01*d.* for men and 9·09*d.* for women. So far as men are concerned the scheme could therefore be met out of the present contribution; so far as women are concerned it could not. We are forced, therefore, to abandon this proposal not only on the ground that it involves for lower benefits a higher rate of contribution for women than for men, but also and mainly, because it would involve an increase in the present contribution for women.

Increase of Standard Rate of Disablement Benefit.

312. As an alternative to the above proposal we have considered the possibility of an increase of disablement benefit only. It was suggested to us by some witnesses (e.g. *Cohen*, App. LXXVI, 9 : Q. 19,802; *National Association of Trade Union*

Approved Societies, App. XCII, 111-112; Q. 22,049, 22,052; *Standing Joint Committee of Industrial Women's Organisations*, Q. 23,151), that there is no logical reason why the rate of benefit should be reduced after 26 weeks of illness, as the need for financial assistance would ordinarily become greater with the prolongation of illness; and it was urged upon us that in order to mitigate to some extent the distress which must often arise by reason of the scanty provision afforded by the present disablement benefit, the rate of that benefit should be increased. This point of view commands respect, but the proposal to which it leads must be examined in the light of experience. On this it has to be said that the reduction of the rate of benefit after 26 weeks is not a novel feature of sickness insurance introduced for the first time by the National Health Insurance Act. While the period after which it is made is not invariably 26 weeks, such a reduction is universal in the practice of Friendly Societies and of those Trade Unions providing sickness benefit. The necessity for it has arisen on financial and administrative grounds, and we are advised that in the few cases in which in the past Societies have attempted to dispense with it, the hard facts of experience have enforced its adoption upon them. The present system, so far from having gone unquestioned, was the subject of attack, on the very ground submitted by our witnesses, so long ago as 1835, when Ansell dealt with it in his treatise on Friendly Societies. The writer in question was an actuary of eminence in his day, and his views might have been expected to obtain a considerable degree of acceptance. In this respect they either failed to appeal, against the teachings of experience, or if put into practice, were discarded when their impracticability was demonstrated.

313. We cannot ourselves assume the responsibility of advising that the lessons of experience on this important subject should be disregarded however reasonable in logic is the plea submitted to us. We have nevertheless thought it proper to refer the matter to the Actuarial Committee. It will be seen from their Report that after making allowance for the recent experience as to the cost of disablement benefit and for a further margin of 20 per cent. to meet the strong probability, dictated by the practical experience to which we have referred above, that an increase in the rate of disablement benefit would involve a greater frequency and a greater duration of claims, the margin in the present contribution would allow for an increase of 2*s.* 6*d.* a week in the case of men but only of 9*d.* a week in the case of women. Here again we are faced with the difficulty that within the limits of the present contributions, men would be given a substantially better treatment than women. We do not think that a mere addition of 9*d.* to the present rate of 7*s.* 6*d.* is worth serious consideration. Beyond this, as we have indicated, we are very much impressed with

the potentialities of serious difficulty, financial and administrative, which are latent in an increase in this particular benefit, and we can accordingly make no recommendation of the kind for which we have been asked by the witnesses who have brought this question to our notice.

Dependants' Allowances.

314. As a third possibility we have examined the question of providing allowances for dependants similar to those under the Unemployment Insurance Scheme, leaving the basic rates of sickness and disablement benefits unchanged.

315. From the Second Report of the Actuarial Committee it will be seen that calculations have been made of the effect of giving the same rates of allowance as under that Scheme; but as these would bring the contribution for men up to $9\frac{3}{4}d.$ a week we have ruled out this possibility and turned our attention to two other possible plans either of which could be financed within the present contributions. These are (1) an addition of $3s.$ a week to the sickness benefit in respect of a wife and an addition of $6d.$ in respect of a child, one-half of these rates being provided during the payment of disablement benefit, (2) an addition to the sickness benefit in respect of either a wife or a child of $2s.$ a week with a proportionate addition of $1s.$ a week to disablement benefit.

Of these two schemes we prefer the second, mainly on the ground that the former, involving as it does a rate of $6d.$ a week for any dependent child could hardly in that respect be of much practical value.

316. A question of some difficulty which calls for consideration at the outset, relates to the provision to be made in respect of wives and the extent to which that provision should be affected by the consideration that in certain circumstances the wife, being herself a wage-earner, is not wholly or in many cases even partly dependent on her husband. We have come to the conclusion, however, that for Health Insurance purposes the wife should in all cases be regarded as dependent on her husband, and that accordingly the additional allowance should always be paid in respect of the wife, even where she is herself a wage-earner. It is true that such a wife is not ordinarily a dependant for the purposes of the additional allowance payable under the Unemployment Insurance Scheme. In the circumstances of the Health Insurance Scheme, however, we consider that the proposal which we advocate can be supported not merely on very cogent grounds of administrative convenience, but on other grounds substantial in themselves. At present wage-earning wives are largely concentrated in certain parts of the country (as in Lancashire) and in certain Societies, and if wage-earning wives were excluded from any Scheme for the payment of dependants' allow-

ances under the Health Insurance Scheme, there would be introduced a new factor which would operate to the financial advantage of certain Societies as compared with others and which would accordingly increase the number of influences making for deviations from the general average experience among Approved Societies.

Definition of Dependency.

317. We have spoken above of allowances for dependants in general terms. It is now necessary to consider a little more closely what should be the scope of the term " dependant " to be adopted for the purpose of the benefit. In this connexion we would direct attention to Sir Walter Kinnear's reply to Question 23,460.

318. The statutory definition adopted for the purpose of Unemployment Insurance is sufficiently wide to include such persons as the housekeeper of a widower who has charge of his children, or an " unmarried wife." The provision of dependants' allowances to persons of these types is perhaps relatively simple in the case of Unemployment Insurance, as this is administered by a Government Department which is in a position to issue exact instructions to all its local branches and thereby to enforce uniformity in the distribution of benefits throughout the whole insured community; but in regard to Health Insurance the case is otherwise. and we think that the administration by Approved Societies of dependants' allowances in respect of such persons would be an extremely difficult matter.

319. Another consideration to which we must have regard in the case of the unmarried wife is that the granting of such allowances would be inconsistent with the title to a widow's pension under the Widows', Orphans' and Old Age Contributory Pensions Act. Many Approved Societies would, moreover, probably raise serious objection to making payments in such cases.

320. We have considered the practicability of limiting the definition to " those persons living in the household who are dependent upon the insured person, and any of his children residing outside the household." It has, however, appeared to us very desirable to avoid any definition which would place upon Approved Societies the onus of making inquisitorial investigations into the private circumstances of a member and his household. Further, the adoption of this definition would add very materially to the administrative difficulties of the Societies, and would probably be followed by a claim from the Societies for a substantial increase in the amount allowed for administrative expenditure.

321. With regard to those cases in which husband and wife are both insured persons, we consider that the payment of dependent children's allowances in the event of the illness of

either the father or the mother would not be justifiable economically, and in particular would tend to absorb a large part, if not the whole of the margin in the women's contribution for the advantage of the small minority of insured women who are married, and whose claims already impose a heavy burden on the contributions of the whole body of insured women. We think, therefore, that in all cases children should be regarded as dependent upon the father only, and that dependent children's allowances should not be paid from the mother's insurance where both she and her husband are insured persons.

322. We think that the case for dependants' benefits would be reasonably met and that Societies would be relieved of the necessity of making undesirable inquiry into family circumstances if provision is made on the basis that if the insured man is married 2*s*. a week is to be added to Sickness Benefit in respect of his wife and 2*s*. in respect of each child under 14, and if he is a widower, and has dependent children, 2*s*. is to be added to the weekly sum payable in respect of these children. The addition to disablement benefit would be 1*s*. a week in each case.

323. With regard to the case of widows with dependent children, we have considered the possibility that in view of our recommendation to grant in the case of widowers an allowance additional to the children's allowances, a similar concession would be claimed on behalf of insured widows. We think, however, that as the widow will, in virtue of her husband's insurance, be usually in receipt of a pension under the new Widows' Pensions Scheme, she has no strong claim on the ground of need to this allowance, while we are averse to making a further addition (for which all insured women must contribute) to the heavy increase of benefit which children's allowances will represent in the case of a very small class among the women in insurance. In the case of widows, we accordingly suggest that the allowance for dependants should be 2*s*. a week for each dependent child in the case of sickness benefit and 1*s*. a week in the case of disablement benefit.

324. In the case of the insured woman whose husband is uninsured, we have come to the conclusion that the principle to which we have already referred, viz., that the husband must be regarded as responsible for the children, must be adhered to, especially as this principle was definitely accepted by Parliament after full discussion on the Widows', Orphans' and Old Age Contributory Pensions Bill. We feel, moreover, that it would be inequitable to discriminate between the uninsured and insured husband, and to give the former an advantage over the latter. For these reasons we suggest that where the husband is living and uninsured, dependent children's allowances should not be paid from the wife's insurance.

325. With regard to unmarried insured women with dependent children, we do not consider that the allowances should be paid in respect of the children, as an awkward problem of actual dependency would inevitably arise in regard to maintenance orders awarded by a Court and would raise serious administrative difficulties. But we do not think it just that unmarried women, who constitute the great majority of insured women, should have to contribute for a benefit which very few of them are ever likely to receive. We have therefore considered carefully in what circumstances an unmarried woman could fairly claim that her sickness or disablement benefit should be supplemented by an allowance for a person dependent on her. We have come to the conclusion that the allowance might be made in such a case in respect of a dependent widowed mother. It should, however, be laid down that where a widowed mother is alleged to be dependent upon an unmarried insured daughter, but also has unmarried sons to whom she can reasonably look for support, she should be regarded as dependent upon the sons and not upon the daughter.

326. We are informed that under the Widows', Orphans' and Old Age Contributory Pensions Act elaborate machinery has had to be set up for the purpose of securing periodical notifications from schoolmasters of the continued attendance at school of dependent children over the age of 14. Certification to Approved Societies on similar lines would, we suggest, be impracticable, and in view of the difficulties involved in certifying the dependency of children over the age of 14, we suggest that "dependent child" for the purpose we have in view should be defined as a child not exceeding the age of 14.

CHAPTER XII.

CONSIDERATION OF CERTAIN MAJOR PROBLEMS.

327. Our proposals up to this point have absorbed the financial resources which we consider to be available for extensions of any magnitude, viz., the margin in the contribution not actuarially required to support the statutory benefits and the proceeds of the scheme for partial pooling of surpluses which we have proposed in Chapter IX. We now pass on to consider six questions of substantial importance. Some of these do not involve large financial considerations, others do; and where such large financial considerations are in question, we are for that very reason compelled to advise delay in making fundamental changes.

328. The six problems dealt with in sections of this Chapter, are as follows :—

SECTION A.—The extension and consolidation of the maternity services;

,, B.—The promotion of dental benefit to the status of a complete and generally available benefit;

,, C.—The provision of medical benefit to the dependants of insured persons;

,, D.—The transfer of the powers and duties of Insurance Committees to the Local Authorities;

,, E.—The improvement of the position of deposit contributors who cannot secure admission to Approved Societies; and

,, F.—The remuneration of the insurance practitioners and the machinery for dealing with complaints against them.

We take these problems in that order.

SECTION A—MATERNITY SERVICES.

329. In Chapter V we have considered at some length the general problems of a maternity service, especially on its medical side, and have reviewed the evidence which has been placed before us. We have indicated the direction in which we think such a service should develop so that on the one hand all the medical provision will become an integral part of a co-ordinated medical service; and on the other the money benefit will take its place among the cash provisions under whatever system of insurance is then in being.

330. At this point therefore we need only discuss what immediate modification might be made in the existing arrangements for maternity benefit were the necessary funds available. We have been much impressed by the need for something beyond the present relatively small cash payment in view of the great importance to the future generation of adequate supervision and maintenance at the time of childbirth.

331. A large volume of evidence has been directed to show that the sum payable as maternity benefit is almost entirely absorbed in the fees of the doctor or midwife and that very little, if any, money is left over for the other needs of the mother and child. We are inclined to think that the original conception of the benefit was something wider than this. At any rate we do not feel that the payment merely of the fee is an adequate content for a maternity benefit in a developed scheme of health services. And obviously if any expansion were contemplated regard would have to be given, even in any immediate changes, to the medical side of the Insurance Scheme and to the parallel activities under the Maternity and Child Welfare Schemes of the Local Authorities which we have described in Chapter IV.

The Washington Convention.

332. Our attention was directed by certain witnesses, including the National Association of Trade Union Approved Societies (App. XCII, 127-131; Q. 22,058 and 22,087 to 22,096) and Dr. Marion Phillips, on behalf of the Standing Joint Committee of Industrial Women's Organisations (App. C, 17-27; Q. 23,034 to 23,041), to the terms of the Maternity Convention adopted by the International Labour Conference held at Washington in 1919 under the provisions of the Covenant of the League of Nations. These were as follows:—

> "In any public or private industrial or commercial undertaking, or in any branch thereof, other than an undertaking in which only members of the same family are employed, a woman:—
>
> "(*a*) Shall not be permitted to work during the six weeks following her confinement.
>
> "(*b*) Shall have the right to leave her work if she produces a medical certificate stating that her confinement will probably take place within six weeks.
>
> "(*c*) Shall, while she is absent from her work in pursuance of paragraphs (*a*) and (*b*) be paid benefits sufficient for the full and healthy maintenance of herself and her child, provided either out of public funds or by means of a system of insurance, the exact amount of which shall be determined by the competent authority in each country, and as an additional benefit shall be

entitled to free attendance by a doctor or certified midwife. No mistake of the medical adviser in estimating the date of confinement shall preclude a woman from receiving these benefits from the date of the medical certificate up to the date on which the confinement actually takes place.

"(*d*) Shall in any case, if she is nursing her child, be allowed half an hour twice a day during her working hours for this purpose."

333. The witnesses urged that this Convention should serve as a model in considering the provision to be made for maternity in this country. We would point out, however, that the Convention is confined to women who are themselves engaged in industrial or commercial employment, while under the Health Insurance Scheme we have to consider not only these women but also those in domestic employment, and the vastly greater number of women who are not themselves employed but are the wives of insured men. As we shall show, our problem is an essentially different one from that which was before the framers of the Washington Convention.

Character of Maternity Benefit.

334. Both the Washington Convention and the Maternity and Child Welfare Schemes suggest to us that maternity benefit must in the present state of thought be considered in close connexion with the wider question of the provision to be made for women immediately before, during, and immediately after childbirth. It is not so much the money payment that is of importance as the question of taking steps to secure that every woman receives proper attention from doctor or midwife in suitable surroundings during a reasonable period centred on the confinement. In other words the character of the benefit should change from "cash" to "health" and it should be linked up with the other related health services. This is not to say that there should be no cash payment at the time of confinement. Such a payment is undoubtedly of value and will be utilised wisely by most mothers; but other elements must, we think, eventually be introduced.

335. The existence side by side of the maternity benefit under the Insurance Scheme, the arrangements made under the Maternity and Child Welfare Schemes, and the provision under the Poor Law illustrates the variety which characterises the existing National Health arrangements to which we have adverted elsewhere. In this instance we have three independent authorties administering in the same area schemes governed by different social and financial principles, but all attempting to solve the same problem—the assistance of the

mothers who in varying degrees do not or cannot meet their difficulties by purely individual effort.

The Medical and the Maintenance Elements.

336. It may at this point be of interest to submit some details of the cost of an extended maternity service which have been provided for our use. There are two main groups of elements which have to be considered. In the first place there are the medical services, with a cash payment to the woman to enable her to buy any necessaries and comforts incidental to the occasion. In the second place there is the provision of maintenance for the working mother and her child during a specified period before and after the confinement on the condition that remunerative work is given up during these periods.

Cost of the Medical Provision.

337. The average number of confinements in respect of which maternity benefit is payable is estimated to be 717,500 per annum, of which 517,500 are cases of uninsured women. The first of the new requirements would seem to be provision for medical examination, ante-natal and post-natal. An outside fee for these examinations would be 5*s*. each (10*s*. in all). It is open to argument whether, as regards insured women, these particular services are not to a great extent included within the scope of the medical benefit to which the women concerned are entitled, and are therefore covered by the obligation which at present rests on the insurance practitioner. For the purpose of our estimate we have treated them as new services, but this must not be taken as an expression of opinion on the content of the present medical benefit in relation to the class in question.

338. The second requirement is the provision of ordinary medical care during the period of pregnancy. Apart from attendances which would be necessary in all cases as part of the ante-natal treatment, the risk of ordinary attendances being required during pregnancy is clearly higher than it would be at other times. Even if the doctors were prepared to undertake this new service on a contract basis it cannot be assumed that they would be willing to accept payment on the basis of the ordinary capitation rate applicable to insured persons generally. The offer of free medical attention in the ante-natal period might be expected to result in consultation with the doctor regarding pregnancy at an earlier date than is otherwise usual. Assuming that on the average the doctor would be informed at the end of the second month, the payment on the basis of a capitation fee of 9*s*. a year would be 7/12ths of this amount, or 5*s*. 3*d*. But the present

capitation rate is based on an experience which shows that roughly half the persons entitled to medical benefit do in fact receive some attendance during the year. It would probably be contended that practically all pregnant women would require attendance at some period during their pregnancy (apart from any attendance for the purpose of examination) and that the doctor's obligation would be regarded as double the risk in ordinary cases. On this basis the fee for a general seven months' liability would become 10*s*. 6*d*. This charge would not arise in the case of insured women, since the service is covered by the present medical benefit.

339. The other medical service for which provision would have to be made would be the risk of the doctor being called in to attend at confinement in cases beyond the skill of the midwife. An estimate of a fair payment to cover the risk of having to attend at the confinement has been arrived at from information, obtained from Local Authorities, as to (1) the total number of cases in the areas of those authorities attended by midwives; (2) the number of these in which doctors were called in by the midwives, under the Rules of the Central Midwives Board, and a fee claimed from the authority; and (3) the total amounts paid in fees to those doctors. This, for various reasons, does not give the exact average cost, spread over all confinements, of the aggregate fees paid where doctors were called in. The data for a precise adjustment do not exist. But the margins of possible error are not great, and it may fairly be inferred that a charge of 2*s*. 6d. per confinement attended by a midwife would yield a fund sufficient to defray all the doctors' fees payable under existing conditions. Under a scheme of the kind under consideration, there would, however, be a large increase in the number of cases in which the doctors were called in, and to cover this increased risk of attendance a higher fee would have to be paid per case accepted. Probably 4*s*. would suffice, but to avoid an under-estimate it has been taken at 5*s*.

340. There remains to be considered the amount to be allowed by way of cash benefit. Though much general evidence on the question of the absorption of the present maternity benefit by the doctor's or midwife's fee has been received the figures supplied to us have varied within wide limits. The average fee now charged by midwives would seem to be about 30*s*. and the amount available for other purposes in the case of women entitled to only one maternity benefit would thus be about 10*s*. We feel, however, that this sum would be too small to be of much practical value and we could not recommend a lower cash payment than 20*s*.

341. On this basis the cost per case would work out as follows :—

	£	s.	d.
(1) Fee to midwife	1	10	0
(2) Fees to doctor for ante-natal and post-natal examinations (5*s*. each)		10	0
(3) Fee to the doctor to cover risk of personal attendance at confinement		5	0
(4) Cash benefit	1	0	0
	£3	5	0

And in the case of uninsured women only :

(5) Payment to doctor to cover other medical attendance during the ante-natal period, already provided for insured women as part of medical benefit ...		10	6

The total charge on this basis would be £3 15*s*. 6*d*. in the most common case in which the husband was working but the wife was not. Where, however, the mother was herself an insured person a portion of the liability would be covered by the existing medical benefit and the corresponding charge would be £3 5*s*. If both husband and wife were insured persons one set only of medical charges would arise, but a further 20*s*. would be appropriate as a cash payment in respect of the wife's own insurance and the total charge would thus be £4 5*s*. In this case also questions arise as to the apportionment of the charge between the husband's Society and the wife's Society. The adoption of this scheme would involve the abolition of the present incongruous arrangement under which in the case where the husband of an insured married woman is not himself an insured person her Society is required to pay to her a double maternity benefit.

342. We referred to the Actuarial Committee the question of the cost which would be involved in replacing the present maternity benefit by a provision on the lines indicated above and the matter is dealt with in the Third Report of the Committee which is printed in Appendix A to our Report. It will be seen that on the assumptions set out in the Report, the additional cost would be such as to impose a charge of ·44*d*. per week on the contribution payable in respect of men, while reducing the charge on women's contributions by ·11*d*. per week. If, therefore, the provision were limited in accordance with the proposals outlined above and further explained in the Report of the Actuarial Committee, and if this provision were made, the next charge on the margin in the present weekly contribution after meeting the balance of the cost of the present medical benefit, it would be possible to defray it out of the present resources of National Health Insurance.

343. We have given long and careful consideration as to whether we should recommend that this improved provision for maternity should receive second place in the extensions to be recommended by us, the first place having been allotted to the provision of a specialist and consultant medical service. We fully recognise the importance, in the interests of the health of the nation, of doing everything possible to insure that women should have skilled attention during pregnancy and childbirth, and we were impressed by the evidence submitted to us as to the failure of the present maternity benefit to effect any reduction in the rate of maternal mortality. Finally, however, we came to the conclusion that the second place in our recommended extensions should be given to the provision of allowances to the dependants of insured persons in receipt of sickness or disablement benefit, and that extended provision for maternity should be given the third place, with the result that it cannot be included in the extensions which will become immediately practicable under the financial re-adjustments which we recommend in Chapters VII and IX of our Report. It was with considerable reluctance that we arrived at this decision. Apart from the claims, on its own merits, of the proposal for giving allowances in respect of dependants, we were influenced by the consideration that it was of the utmost importance that any scheme for making better provision for maternity should be linked up in the closest possible way with the maternity and child welfare work of the Local Authorities. There might, therefore, be some advantage in refraining from change until the Local Authority has become (as we propose) responsible for the insurance medical service as well as the other public health services, and has had time to take stock of the position on both sides of its work and to familiarise itself with the new problems which will arise.

The Problem of Maintenance.

344. Turning now to the other aspect of the question as represented to us by witnesses, viz. : the provision of maintenance for mother and child, we have found some difficulty in arriving at a reliable estimate of the cost which would be involved and we foresee many difficulties in the administration of such allowances as are proposed. On this matter also we sought the guidance of the Actuarial Committee. In reply it was pointed out to us that the problem of intention to resume work must necessarily arise, and that calculations could not be made authoritatively until the method of dealing with that problem had been settled. The aim of the advocates of this part of a maternity scheme is to provide for the wage-earning woman so as to recompense her for the definite pecuniary loss incurred by her withdrawal temporarily from employment by reason of her pregnancy and confinement. The difficulty of determining whether or not a par-

ticular woman, who leaves her work some time before her confinement, has definitely given up her status as a wage earner lies at the root of the matter. Some test would have to be applied if the right to benefit depended on the settlement of the point. The choice of a test which is equitable and at the same time easy to apply has in similar circumstances in the past, e.g., in the original provisions of the 1911 Act relative to insured women giving up their work on marriage, proved to be so serious a difficulty as to have led to the abrogation of the system under which it arose, the right to benefit being now based on entirely different considerations

345. We have considered, as a possible way of meeting the difficulty of ascertaining "intention," a suggestion that the benefits should be paid at the confinement of every insured married woman, whether she was an ordinary employed contributor or in the special class (Class K), or in the ordinary free year's insurance following cessation of employment. Under this plan the benefit would be paid yearly to about 91,000 women in Class K and to about 94,000 women who were either employed or in the free year. The number in the free year is probably relatively small. The suggestion then comes to this, that in order to pay about 90,000 women, who are normally working so as to induce them to stay away from work before and after confinement, payment would also have to be made to at least 90,000 other women who have recently married and in whose case the presumption is that they have entirely given up work. We do not think that such a result can be contemplated. In the circumstances we have not felt justified in asking the Actuarial Committee to proceed further with the subject.

346. To one general point we may in conclusion refer. It would appear open to question whether in practice the benefits of this type could be, for long, limited to employed women. It seems not unreasonable to assume that following the adoption of such a scheme for the wage-earning mothers there would spring up an immediate and insistent demand for the extension of the benefits—or at any rate a part of them—to all mothers irrespective of any question of employment. Such a demand would be peculiarly difficult to resist. It would be urged—and with good reason—that the home-keeping mother was as deserving of the assistance of the State as the woman who had continued in industrial employment. The contrast between the position of the home receiving two sets of wages and the maintenance benefit with that receiving only one set of wages would be too marked to escape criticism. And if such criticism led to the extension of the provision to all mothers, the cost would at once be enormously increased and an expenditure of £6 to £8 millions a year, for maintenance alone, might have to be contemplated.

347. This consideration is in our opinion sufficient in itself to render impracticable for the present the suggested modification of the existing provision for maternity in the direction of providing for the maintenance of the mother and child; and, taken in conjunction with what we have said above as to the provision of medical services during pregnancy and confinement forces us to the conclusion that for the present the existing arrangements for Maternity Benefit should in their general outline remain unchanged.

SECTION B.—DENTAL BENEFIT.

348. Dental benefit is, as we have pointed out in Chapter V, one of the most popular, if not the most popular, of the additional benefits, and as such it is available in some form or another to large numbers of insured persons. The membership of all the Societies and Branches in England which provide this additional benefit reaches a total of about 10,700,000. The desirability of making it a normal benefit under the Act, available under uniform conditions to the whole insured population, has been urged upon us from many quarters, and much evidence, a summary of which has already been given in Chapter V, has been submitted to us by responsible professional and lay witnesses. The advantages to general health and the consequent beneficial reactions upon the benefit funds have been specially pressed upon our notice. Nevertheless we do not propose to recommend that any substantial change in the present arrangements should be made in the near future. It is therefore desirable that we should examine this problem at some length to justify the conclusion we have arrived at in the face of so much evidence.

349. It is mainly the question of cost which has caused us difficulty in this matter and to that we will now turn. The evidence received from such Societies as have given Dental Benefit and from the professional bodies suggests that the cost of this benefit on a complete basis would be—in the initial period and before the accumulation of dental defects has been overtaken—in the neighbourhood of 5*s.* or 6*s.* per annum per insured person. (See, e.g., *Hearts of Oak Benefit Society*, Q. 3553-3558; *Gordon*, Q. 7727; *Joint Committee of Approved Societies*, Q. 8725; *National Insurance Beneficent Society*, Q. 8828; *British Dental Association*, Q. 9246-9247; *British Society of Dental Surgeons*, Q. 9487, 9519-9521, 9566-9578; *United Women's Insurance Society*, App. XXIV, 38-39, 51; Q. 10,284, 10,287-10,291; *Brock*, Q. 23,939; *Leishman*, Q. 24,381-24,386.) In fact the Scottish Board of Health put the cost as high as 7*s.* 6*d.* per insured person per annum. In view of the heavy annual cost thus foreshadowed we have thought it well to invite the Ministry of Health to give us more precise indications not

only of the cost, but of the scope and administrative arrangements of such a service.

Cost of a Statutory Dental Benefit.

350. The cost of providing a dental service for all insured persons cannot we are told be determined with any precision because of the impossibility of estimating accurately the number of persons who might apply for treatment. It is generally agreed that the dental condition of the industrial classes is deplorable. The proportion of insured persons needing some form of dental treatment is put at from 60 per cent. to 80 per cent. of the total. The precise figure, however, is not material, even if it were exactly ascertainable, since the important point in framing any estimate is not the number of persons who need treatment, but the number who would be likely to seek it. This must be a matter of conjecture, but it is material to note that the demands on Approved Societies which have provided dental treatment as an additional benefit have shown a marked and continuous increase. With an unrestricted dental service, open to all insured persons without any contribution being required from patients, it would, we are told, not be safe to calculate on less than 5 per cent. of the total insured population applying for treatment in a year. We understand that the percentage of members eligible for the existing Dental Benefit who apply for treatment is about 4 per cent., but allowance must be made for those who are deterred from applying by the knowledge that they will have to bear part of the cost. In the case of the United Women's Insurance Society the proportion of applicants has been as high as 9 per cent., a figure which is significant in view of the long experience of this Society in the provision of dental treatment. (App. XXIV, 22-51.)

351. The other item in estimating the cost of a dental service is the cost per case treated. It is clear that the majority of persons now applying for treatment need dentures, and until the present arrears have been worked off, which would take some years, the proportion of denture cases is bound to be very large. The inevitable result is that the cost per case treated is high. In the initial period it would not be safe to estimate the average cost per case at less than £4, and it might prove to be nearer £5 on the basis of the present scale of the Public Dental Service Association. It is possible, though by no means certain, that some saving might be effected by the adoption of a system of remuneration based upon the time given to the work in preference to one based on a scale of fees for services rendered.

352. Accepting for the moment the estimate of 5 per cent. of insured persons applying for treatment in each year at an average cost of £4 per case, estimates which are probably on the low

side, it follows that an unrestricted non-contributory dental benefit would cost at least 4*s.* per insured person per annum, which is the equivalent of a penny contribution. If the percentage of applicants exceeded 5, as in course of time it probably would, or the average cost per case exceeded £4, as in many areas it does at present, the total cost of a "100 per cent." service would exceed the equivalent of a penny contribution.

353. The establishment of a complete dental service for the insured might, as we have said, be followed sooner or later by a reduction in the expenditure on sickness and disablement benefits, which would to some extent be a set off against the new expenditure. But this is a wholly conjectural factor, and no effect can be given to it for the purpose of framing actual estimates.

Methods of Restricting Liability.

354. If an unrestricted service is too costly under present conditions, the question arises whether the liability could be limited. In examining possible methods of limitation we have to weigh the ultimate gain in the improved dental condition of the insured people against the claim to immediate relief of those actually suffering in health owing to neglect of the teeth. From the medical point of view there are obvious advantages in concentrating on the treatment of young persons and in spending the money on conservative work. But such a policy is not likely to be acceptable, since it does nothing for those older persons whose mouths are in such a condition as to produce digestive and other disorders resulting in present suffering and, what is important as an insurance consideration, consequent demands on the benefit funds. The two conflicting points of view might possibly be reconciled by making no charge for conservative and operative treatment, but requiring the insured person to contribute a substantial proportion (say 50 per cent.) of the cost of dentures. Such a proposal is open to the obvious objection that it would tend to exclude the most necessitous of the insured population who need dentures and who could not afford £2 or £3 towards their provision. (See *Brock*, Q. 23,943.) This difficulty might, to some extent, be met by allowing Societies some discretionary power in cases of proved need to contribute the balance as an additional benefit. We recognise that such discretionary benefits are difficult to administer and are liable to abuse. But it does not seem to us impossible to devise tests which would afford at least a partial safeguard against administrative abuses. No restricted service can ever be quite satisfactory, but the restriction we have suggested seems to us least open to objection.

355. An alternative method of limitation would be to make the benefit recommendatory and to leave the selection of cases to the Insurance Committees or their successors, on the basis

of some general rules which would determine the order of priority. A recommendatory benefit is open to the administrative objection that it creates expectations which can only be partially fulfilled and is, therefore, likely to give rise to a continuous agitation for increased financial provision.

356. But, apart from the administrative or social objections, the proposal seems to us open to criticism on medical grounds. The fundamental difficulty is that the selection has to be made by lay administrators on the basis of reports by doctors who are each reporting on their own patients and necessarily can have no opportunity of considering the cases in relation to one another. It must in practice be extremely difficult for any committee, even with expert guidance, to arrive at any true estimate of the relative needs of a number of cases on the basis of reports which in the nature of things cannot be relative. Further any system of priority must tend to give a preference to the cases in which the need for treatment is most obvious because they have been so long neglected. In practice it would mean that most of the money would be spent on the treatment of "end-results," and however long such a scheme remained in operation the dental state of the younger insured people at the end of the time would be nearly as bad as at the beginning.

357. So long as Approved Societies are administering an additional benefit with only a limited amount of money available, the selection of cases on the basis of urgency is justifiable, and Societies could not be blamed for adopting the method of selection which promises most immediate reduction of their sickness benefit claims. But the establishment, as a permanent part of the insurance system, of a dental benefit which made no provision for conservative treatment would be open to grave criticism. Theoretically this difficulty could be avoided by a suitably devised table of priority, but in practice this would be very difficult to frame, and the tendency of any system of selection must be, as already explained, to concentrate the expenditure on the cases least hopeful from a medical point of view. It has to be remembered also that a statutory benefit is judged by a standard very different from that applied to additional benefits. An additional benefit is in the nature of a windfall; it is better than nothing, and the insured person thinks himself lucky to get it. But a statutory benefit is on a different footing, and is subject to far more critical scrutiny. A selective benefit which makes no adequate provision for the treatment of early cases would be in our opinion a most unfortunate policy to adopt.

Cost of a Restricted Service.

358. As already indicated, an unrestricted dental service could not be provided for less than 4*s*. a head per annum. Indeed, it

would probably not be safe to attempt to provide such a service if the amount available was less than 6*s*. While we do not anticipate that the cost would be as high as 6*s*. at first, it might easily approximate to this as insured persons become better acquainted with their rights and realise the advantages of dental treatment. But we think that the restricted service we have suggested could be provided at the outset for about 3*s*. a head if the insured persons were required to contribute half the cost of dentures. A contributory scheme would reduce the number of applications, and the saving on denture cases would be considerably more than the amount contributed by the insured persons. But if the sum which it will ultimately be found possible to set aside for this purpose proves to be less than 2*s*. 6*d*., it would not in our opinion be desirable to attempt to provide a general dental benefit. A dental service costing less than 2*s*. 6*d*. a head would not be worth offering. The restrictions necessary to keep the cost within any lower limit would make the benefit irritating and to a large extent illusory. Treatment would tend to become a matter of chance rather than of right.

359. An alternative suggestion, which has much to commend it on medical grounds, would be to provide all conservative and operative treatment free but to leave dentures to be paid for by the patient or to be provided by the Approved Societies as an additional benefit. Such a dental service would be of great value to the younger insured persons and would not be costly to provide; but a benefit which fails to provide the one form of treatment which the older insured people desire is not likely to be welcomed and we have not made any attempt to estimate the cost on this basis.

Method of Payment of Dentists.

360. If dental benefit were to become a normal benefit the question of the method of payment of the dentists might arise as a more important issue than it does at present. With the precedent of the success of the capitation method in medical benefit before us, we thought it desirable to examine witnesses on this point. Mr. Brock, in reply to Q. 23,952, stated that "dental benefit does not lend itself to payment on a capitation basis at all. To begin with, there are no sufficient data available on which you could calculate a capitation rate, and if the adoption of a capitation system were proposed to the dentists they would be tempted naturally to insure themselves by demanding an excessive rate." He goes on in the same reply to cite other objections of a fundamental nature, and adds that there are really only two practicable methods of payment, one the attendance basis with an agreed scale specifying the fee for each separate kind of service, and the other, payment

by time at so much per session. The latter method is difficult of application, except where a clinic is established. The former is difficult to administer economically unless estimates are submitted in advance and some system of inspection and supervision is provided.

General Conclusions.

361. Reviewing all these considerations, we come to the conclusion that no change should be recommended at present in the main provisions for dental treatment. A complete dental service would be eminently desirable. But it would cost about £4½ millions a year, or 1½*d.* on the contribution. A partial service has, as we have indicated, many defects and difficulties, medical as well as administrative. Any reasonable partial service would cost about £2¼ millions a year. Even this smaller sum is not available within the present financial limits after provision has been made for those two extensions of benefit already described, which we think should rank higher in order of priority. Quite apart from financial considerations, there are indeed grounds on which it might be suggested that delay in this matter may not be wholly disadvantageous. The benefit, administered as an additional benefit, is still in an experimental stage, and much may yet be learned from further experience of its operation in its present form. On such questions as those of the cost involved, the reaction of dental treatment on health, possible methods of organisation and control, there is room for greater and more accurate knowledge than we possess at present; and it might reasonably be held that, in a matter of such great moment, we shall have a better prospect of building securely in the future, if meanwhile we are content to wait until a somewhat fuller experience has been gained. In the varied system of provision of dental services as an additional benefit by numerous Approved Societies a useful arena for such experiment is given. Under these schemes 3,485 Societies and Branches in England, with a membership of about 10,700,000 insured persons, provide some form of dental treatment, and this number will certainly be increased when all the schemes under the second valuation become operative. In refraining from recommending dental treatment as a normal benefit, we are by no means leaving the insured persons without any provision at the cost of the insurance funds for the care of their teeth. Moreover, we consider that it is not irrelevant to the question before us to observe that the Dental Profession, consequent on the passing of the Dentists Act, 1921, is at present in a state of transition, and it might accordingly be suggested on various grounds that the present is an inopportune moment to inaugurate a comprehensive scheme of dental benefit administered universally as a normal benefit under arrangements made by the Central Department on lines similar to those which govern medical benefit.

A Regional Dental Staff.

362. But we should be sorry to leave this question without making any practical proposals at all. And we do make one now which we consider will have beneficial effects on the somewhat varied collection of additional benefit schemes for dental treatment. We refer to the institution of a Regional Dental Staff. No insurance dental service can, we are told, be satisfactory without effective supervision, especially over the quality of materials and standard of workmanship used in dentures. (See *Brock*, Q. 23,952.) In the experience of the Ministry of Pensions we understand that in one pension area 35 per cent. of the cases examined were stated to be unsatisfactory. This did not mean that 35 per cent. of all the work done was unsatisfactory, since the cases examined included all those in which any complaint had been made by the patient.

363. A Regional Dental staff would be responsible for the examination of all estimates, and would actually see a proportion of the cases after treatment was complete. The proportion of cases seen need not, apart from complaint cases, be large. The value of such a system of inspection is to a great extent psychological, and the effect is due to the knowledge that any particular case may come under scrutiny.

364. It is clear to us that if dental benefit is eventually made universal, a system of regional officers would be essential for its successful operation. If, realising the larger alternative, dental treatment were to become one element in a general health service for the whole population, some such arrangements would be equally necessary. But even at the present stage of additional benefits there would be a real value in establishing a partial system of control which could naturally develop into the fuller scheme. In fact, just because the present system is so varied in its methods and provision, it may be held that some such control is specially needed.

365. As to cost, we have received from the Ministry of Health an estimate for a Regional Dental Service, on the assumption of dental benefit being universally available on uniform terms. Twenty-one Regional Dental Officers are suggested, each with a clerk, and all under the control of a chief inspector at headquarters. With due allowance for travelling expenses, office accommodation, &c., the cost is estimated at £31,000 a year. For the service under present conditions the cost would be substantially less. We have not received an estimate for such a limited provision, but even if it approached the above-mentioned figure we would recommend the expenditure as a very desirable means of improving the present service. As the activities of the Regional Dental Service would in very considerable measure tend to protect the expenditure of the Approved Societies on additional

benefits, and as the greater efficiency of the treatment would in the long run tend to conserve the Benefit Funds, we think it only fair that a substantial proportion of the cost of the Regional Dental staff, if it is established, should, as in the case of the Regional Medical staff, be borne by the Approved Societies concerned.

SECTION C.—EXTENSION OF MEDICAL BENEFIT TO THE DEPENDANTS OF INSURED PERSONS.

The Question of Cost.

366. Two important and independent considerations arise when we approach this problem. In the first place there is the question of cost, which on any reasonably safe assumptions must be very considerable and must necessarily at this stage be dependent upon a number of factors difficult to estimate with any accuracy.

367. The terms upon which the medical profession would be prepared to undertake the service would necessarily have to be a matter of negotiation, and it might happen that if an initial rate were agreed actual experience might lead to a demand for its revision. Such an extension of medical benefit would bring in two classes of persons who require to be considered separately, (1) the uninsured wives of insured men, and (2) children up to the age of entry into insurance. Broadly speaking, married women may be expected to require more attendances than the average of insured men. Children up to the age of about three would also require more attendances than men; but children from three to sixteen would probably require considerably less, partly because many of the ailments of most frequent occurrence during school ages are those for which provision is made through other Health Services, e.g., infectious diseases and the minor ailments dealt with by the School Medical Service. In any event, the doctors would not have to undertake any certification duties in the case of dependants.

368. From investigations made by the Ministry of Labour it would appear that for every insured man the number of dependants is on the average 1·5, and for every insured woman ·15, making the total number of dependants 15¾ millions, or slightly more than the total number of insured persons. We may divide these dependants into the two groups indicated by the conclusions in the preceding paragraph (1) children above the age of three, and (2) children under the age of three and uninsured married women. In the former group the amount of medical attendance which would be required would be less than the average for insured persons generally, while in the latter it would be more. On the whole, it would not be unfair to assume that the doctors could afford to take the risk of all the dependants at the present

capitation rate, the extra attendances required for the latter group being set off against the fewer attendances required by the former. The present cost of medical benefit in Great Britain is about £9,000,000 a year, and on the assumptions indicated above the extra cost of extending benefit to dependants would be about £9,500,000 a year.

369. This is a very large sum, and one which far outruns any margin in the present contribution. Even if on other grounds it were felt that this extension merited the first place in the order of priority, the cost appears to us to be prohibitive having regard to our general views on the financial position. An addition of £9,500,000 to the charges on the Benefit Funds would mean an addition of between 2*d*. and 3*d*. to the weekly contribution even supposing that a corresponding addition to the State grant would be forthcoming. Such large expenditure cannot, we think, be contemplated in present circumstances.

370. But quite apart from cost, there are certain general considerations of policy which lead us to the conclusion that this extension is undesirable if it were proposed within the ambit of the present Insurance Scheme. Before we proceed to examine this matter we may give a short summary of the evidence we have received on the question.

Points raised in Evidence.

371. The Loyal Order of Ancient Shepherds (App. XLIV, 35) urge the provision of medical benefit to the dependants of insured persons and are of the opinion that this could be made a first step towards the establishment of a Public Medical Service. They express the view that insured persons would be willing to pay an increased contribution to meet the cost of this benefit. The Independent Order of Rechabites (App. VIII, 30; Q. 6310) think that the provision of medical benefit to dependants would be a distinct advantage to public health and would tend to remove the overlapping which at present exists between the Public Health Services. The Coventry Insurance Committee (Q. 12,299-12,300, 12441-12,442) state that the effect of the non-provision of the benefit to the dependants of insured persons is to set up different standards of health in the community. The Cheshire Insurance Committee (App. XXXIV, B, 21-24; Q. 12, 626-12,630) suggest an increase of the contribution for the purpose of providing medical benefit to dependants. The British Medical Association (App. XLVII, 13-15; Q. 14,843-14,876, 14911-14,913) suggest that medical benefit should be available only to persons with less than a certain income, and that if this income limit is fixed sufficiently low the dependants of such persons should be included. Mr. Cohen (App. LXXVI, 6-7) urges the provision of the benefit, and points out that "the burden of the illness of a wife or child, borne as it is

by the workmen's wage, has in effect the same influence in reducing his standard of living as similar expenditure resulting from his own illness." The National Association of Trade Union Approved Societies (App. XCII, 100; Q. 22,052) suggest the inclusion of dependants in the extended medical benefit which they propose, and submit that "in the average home medical attention and treatment is more often required by the mother and children than by the man. If, therefore, it is considered necessary to protect the worker against the cost of medical services for himself, it is more necessary to protect him against the heavier risk."

Considerations of Policy.

372. Our conclusion on this problem (irrespective of the financial considerations) may, we think, be inferred from certain parts of Chapter V, and here we need not go into any great detail. Briefly, we consider that medical provision for dependants should form an integral part of any scheme of general health services, administered by the Local Authorities. Whether a contribution to such provision is to be made from insurance funds or not, the fact remains that medical service for dependants is too large a problem to be considered apart from medical service for the whole working-class and, perhaps, middle-class population. If the dependants of the present insured population are brought into the system of medical benefit, the residue of the working-class population is relatively small, and that residue may be still further reduced by the proposals for dealing with the destitute poor which are now under the consideration of the Government Further, one effect of including the dependants in the medical service of the present Insurance Scheme might be to impede or postpone any ultimate unification of health services. If this were so, we should all the more be inclined to pronounce against medical benefit for dependants at the present time We may quote Mr. Brock's reply to Q. 23,847 in this connexion: "If a complete medical service, short of institutional treatment, is going to be provided for insured people, of course, it must emphasise the anomaly that at present their wives and dependants can only obtain such medical treatment as they are able to pay for. But it does seem to be open to question whether the better way of providing for dependants is through a system of insurance which must necessarily exclude a certain number of people . . . If it was proposed to provide either a general practitioner service or a complete medical service for the whole industrial population, there are strong arguments in favour of providing this service out of local funds and making it available to all sections of the population . . ." Later he states: "Extension of medical benefit to dependants would be less logical and probably less satisfactory than the establishment of a public medical service at the expense

of local funds." (Q. 23,992.) We also note that Mr. Alban Gordon, who is, at any rate, no reactionary in these matters, has very definitely recommended to us this point of view. He says (App. XIII, 56):

> "I should, indeed, consider the mere extension of medical benefit to dependants of insured persons as a retrograde step, since it would stereotype the present system so deeply as to render it far more difficult to bring into existence at any future date the co-ordinated medical service which the health of the country so urgently needs."

And the National Conference of Friendly Societies, representing those who have for generations carried on the movement for help through insurance, are equally definite. They say (App. XXVI, 35-37):

> "Owing to lack of means, it is impossible for the poorer classes to obtain the services of doctors on fee-paying terms, and for this reason it was deemed necessary to introduce a system of compulsory insurance to include free doctoring. It is submitted that the need is equally great to-day for similar provision for the remainder of the population below an income limit of, say, £250 a year, including the dependants of such persons, as well as those of insured persons.
>
> "If this were done by merely extending medical benefit on its present basis to dependants of insured persons, it would—
>
> "(*a*) greatly intensify the overlapping of services already referred to;
>
> "(*b*) be extremely costly, because a large number of panel practitioners would be, in effect, working full time on payment basis devised for part-time work;
>
> "(*c*) leave out of the scheme at least one and a half millions of persons, including not only the destitute but a number of non-insured persons, such as hawkers, small shopkeepers, &c.
>
> "It is, therefore, suggested that the best way of organising the provision of medical treatment is to merge all existing forms of public medical service (including medical benefit under the National Health Insurance Acts) into one National Medical Service, thereby creating one unified organisation for the prevention and cure of disease. Under this system, the service would be provided for all persons below a given income limit."

373. When a body representing about 4 million insured persons urges these views upon us, we can hardly be accused of disregarding the interests of the insured population if we exclude, as we do deliberately, the provision of medical benefit to dependants

from our immediate recommendations on the Insurance Scheme, and suggest that the matter should be left over to be considered in connexion with any wider proposals for reorganising the health services of the community which may commend themselves to later students of the problem.

SECTION D.—INSURANCE COMMITTEES.

Successful Work of the Committees.

374. We have already mentioned in Chapter V our conclusion as to the disappearance of Insurance Committees not only as part of any future arrangement for the co-ordination of the Insurance Medical Service with other health services, but also as an element of the present Insurance Scheme. As these bodies have played a very important and successful part in the provision of medical benefit during the last 13 years, we must necessarily devote some space to the justification of their proposed demise. We desire to state at the outset that we have had no evidence of failure on the part of these Committees or their officers to perform adequately the task which they had to undertake. On the contrary, their work has been done with a notable degree of success and we have received many tributes to the zeal and thoroughness which have characterised it. For example, Mr. Brock, giving evidence on behalf of the Ministry of Health, states (Q. 23,974) : " But I should like to add that, whatever may be the shortcomings of Insurance Committees as part of the machinery of local government, that is in no way traceable to any failure on the part of their staffs, and I should like to put it on record, if I may, that the clerks to Insurance Committees, with very few exceptions, have carried out their duties, without any precedents to guide them, extraordinarily well, and I think we owe to their work a great deal of such measure of success as has been achieved in the very difficult task of accustoming 12,000 or more doctors to that degree of supervision that participation in the public service implies. The Insurance Committees' staffs have done their work exceedingly well, and I want to make it quite clear that, while I cannot dissent from the general criticism of Insurance Committees, I do want to pay my tribute to the efficiency of the work of their staffs." Sir William Glyn Jones, to whose vigorous recommendations that Insurance Committees should be abolished we shall refer later, in reply to the question (Q. 24,420) whether the officials of the Committees had carried out in an efficient manner the duties falling upon them, replied " Undoubtedly, I think the officials have done extraordinarily well." Again the same witness did not consider that the present position was " due to any slackness on the part of the Insurance Committees themselves or their officials " (Q. 24,402). We would also refer to

the account of the Administration of Medical Benefit given in Section C of Appendix I submitted by the Ministry of Health. There will be found a full official account of the successful administration during 13 years of a very complicated system—and part at least of that success must be attributed to the local administrative bodies. The British Medical Association, representing the bulk of the doctors who are in contract with the Committees and in daily touch with their officials through the administration of medical benefit, make no adverse criticism of their performance and many Societies express themselves as thoroughly satisfied with this part of the machinery.

Two Reasons for Abolition.

375. If, then, medical benefit has been a success, and if the Insurance Committees have been responsible for its local administration, the question may well be asked, Why abolish these bodies? To this we shall attempt to give a two-fold answer. In the first place unification of local effort on health services is, as we have indicated in Chapter V, a consideration that should, in our view, be paramount whatever the success of the isolated pieces of machinery which now exist. In the second place the evidence we have heard convinces us that whatever may have been the position at the outset and whatever the aims of the framers of the Act, in real fact these Committees have not now sufficiently extensive or sufficiently important duties to justify their existence as independent administrative bodies. In 1912, when the Scheme was launched, much may have been gained from the impetus and interest which might be expected from specially constituted bodies. But that stage is long past. The duties are now of a routine character and could equally well be performed by the same officials working under the control of the Local Authority.

376. To the first of these considerations—the need for unification—we need not here devote any space as the principle has been fully discussed in Chapter V, and does indeed, we believe, command general acceptance. We therefore immediately turn to the second consideration and inquire what, in fact, is the present work of an Insurance Committee and what are the views as to the future of these bodies placed before us by critical witnesses. For a full description of the powers and duties of Insurance Committees we may refer to the Ministry of Health statement (Section C of Appendix I), to the evidence of the Federation of Insurance Committees (App. XXXVI) and of the Scottish and Welsh Associations of Insurance Committees (Apps. XXXVII and XXXVIII respectively). These are descriptions of the general system. For a picture in closer perspective of the routine work of, on the one hand, an urban Committee, on the other of a county Committee, we would refer to the statements supplied by the London Insurance Committee (App. XCVIII)

and the Cheshire Insurance Committee (App. XXXIV). We will here attempt to give in broad outline an account of that work.

The Work of Insurance Committees.

377. Insurance Committees, of which there are 128 in England and 17 in Wales, were constituted for every County and County Borough. Three-fifths of the total membership of each Committee are appointed so as to secure representation of the insured persons resident in the area of the Committee. One-fifth are appointed by the County or County Borough Council. Of the remaining fifth two are medical practitioners appointed to represent the medical practitioners in the area, one is a medical practitioner appointed by the County or County Borough Council, and the others are appointed by the Minister. In Scotland there are 54 Committees constituted for the Counties and for the Burghs of 20,000 population and over, and the membership is allocated in very much the same way as is described above.

378. It will be seen that the object of the somewhat complicated arrangements for the membership is to secure majority representation for the insured persons; and at the same time affiliation to the Local Authority in its general aspects, to the Local Authority in its medical aspects, and to the body of practitioners in the area; and to include a small element deriving authority from the Central Departments.

379. Originally the Committees in England consisted of from 40 to 80 members, but in the interests of economy these numbers were reduced to one half by the Act of 1921. In Scotland, however, the original numbers were retained. Normally, members of Committees hold office for three years, but the Committees themselves are corporate bodies with perpetual succession. The number of insured persons for whom the Committees severally are responsible varies very widely. In England, at one end of the scale is the Scilly Isles with 375, and Rutlandshire with 6,000; at the other, London with 1,700,000.

380. The work of Insurance Committees may be broadly classified under the following five heads:—

(1) the arrangements for medical benefit;

(2) inquiries into complaints arising from the provision of medical benefit, including the supply of drugs;

(3) inquiries into the causes of excessive sickness in the area of the Committee and the consequential affixing of liability;

(4) propaganda as to health by means of lectures, leaflets, &c.;

(5) administration of the cash benefits of certain special classes, viz., deposit contributors and members of the Navy, Army and Air Force Insurance Fund.

381. Sanatorium benefit was, until 1921, administered by the Insurance Committees, but in that year was discontinued, the responsibility for the institutional treatment of tuberculous insured persons being transferred to the Local Authority, which already dealt with the uninsured, and the responsibility for domiciliary treatment remaining part of the content of medical benefit.

Medical Benefit.

382. Taking the above five points in order, we have first to consider medical benefit. The normal arrangement by which medical benefit is made available to insured persons is that the Insurance Committee form a list of the doctors and a similar list of the chemists in the area who are willing to treat or to provide medicines for insured persons at a scale of remuneration and under conditions agreed upon by the Committee subject to the approval of the Minister. It was originally intended that these contracts should be framed locally, and that they might vary considerably in nature according to the particular conditions of the several areas. It was found, however, that in practice the whole of the arrangements leading up to the contracts had to be made centrally by discussion between the Departments and representative bodies of practitioners and chemists. The terms so agreed form the basis of the local contracts throughout the country. Local modifications are of a comparatively unimportant character (App. I, C, 35-36).

383. Thus what might have been a very responsible and difficult piece of work has in fact so far as the Insurance Committees are concerned, been reduced to a routine capable of being performed by the local officials under a minimum of supervision by the Committees. The really responsible part of the duty is performed by the Central Departments. And once the lists are drawn up and the contracts signed, what remains for local action is merely the keeping of the index register up to date, keeping similarly the list of insured persons for whom each doctor is responsible, calculation and issue of the periodical payments to doctors and chemists and issue of the medical cards—all of which are essentially matters of machinery.

384. Another matter under this head in which the work of Insurance Committees has been substantially curtailed by the force of circumstances is the pricing of chemists' prescriptions. Originally it was intended that each Committee should do this work for its own area. But in consequence of the uniform tariff agreed upon centrally, it was found much more convenient and much more economical to set up " Pricing Bureaux " to do this work on a uniform method for large areas of the country. In England and Wales there are 15 of these bureaux; in Scotland one for the whole of that country. The duty of the Insurance Committees in this matter is thus reduced to the routine opera-

tion of sending the prescriptions to the bureaux and, on their return, making out the cheques.

Complaints.

385. The procedure for dealing with complaints does raise matters of some moment. A judicial function has to be performed and members of the Committees are called upon to take their part in this. As a complaint may lead to the institution of a Court of Inquiry by the Minister and the finding of that Court may involve the removal of a doctor or chemist from the panel it is obvious that important issues are involved. Indeed it is in this part of the work that we find the only really substantial element in the Insurance Committee's work. We refer to paragraphs 40-49 of Appendix I, Section C, for a description of the procedure for dealing with complaints, and to paragraphs 55-56 of the same Appendix for an account of the procedure for removing practitioners or chemists from the lists.

386. The problem of complaints is, as we have said, important in character. If it were large in volume there might be some justification for continuing the Insurance Committees on this score. But it is not large in volume. In the evidence of Mr. Brock we find (Q. 1070) that the total number of complaints against insurance practitioners which have been investigated by the Medical Service Sub-Committees of the Insurance Committees between 1st April, 1920, and 31st October, 1924, was 1,819 for England and Wales. Of the 1,819, 735 resulted in the doctor being acquitted or the case not substantiated. But taking the total, the number of complaints against doctors per Committee per year is rather less than 3. Even when the complaints against chemists are added (and they are, we understand, equally insignificant in number) it cannot be said that there is here justification for a specially constituted body. We have to bear in mind that the inquiry is not made in the first instance by the Insurance Committee itself but by a specially set up Sub-Committee which reports to the Insurance Committee. Such an investigating committee could, we think, equally well be set up by the Local Authority.

387. Of course, the number of cases of complaints dealt with by an Insurance Committee, though small on the average, may be substantial in the larger urban areas. In London, for example, the number of cases against practitioners dealt with in 1923 was 104 and about 40 cases against chemists arose in the four years 1920-1924. (*London Insurance Committee* App. XCVIII, 31, 48.) The Medical Service Sub-Committee is in this case, no doubt, kept fairly busy. But such a Committee could equally well be appointed by and report to the general Local Authority.

Inquiries into Excessive Sickness.

388. Very high hopes were founded on Section 63 of the Act of 1911 (Section 107 of the 1924 Act) which deals with excessive sickness; but in fact the section has remained a dead letter.

389. We deal in Chapter XIII with the reasons for this, and offer certain suggestions intended to make more practicable the aims of the section, even if on a less ambitious scale. So far as Insurance Committees are concerned, the section would only have had application in respect of deposit contributors, and the problem would therefore have been of small magnitude. But in any case nothing has been done, so that no argument for the continuance of Insurance Committees can be inferred from the existence of this provision.

Health Propaganda Work.

390. Section 50 (1) (*b*) of the 1924 Act empowers Insurance Committees to make such provision for the giving of lectures and the publication of information on questions relating to health as they may consider desirable. It has, however, appeared in evidence given before us that only a very restricted use has been made of this power, owing mainly to lack of funds. (*Brock*, Q. 23,976.)

391. We feel that work of this nature may be made of the greatest possible value in the public efforts to promote health. But in our view it is open to question whether such work, undertaken in the interests of the health of the whole community, should be financed only from insurance funds. We think that duties under this head would more appropriately fall within the province of the local health authority. And our view is reinforced by the opinion of the official witness of the Ministry of Health, Mr. Maclachlan, who said: "Until quite recently the powers of local authorities in regard to Public Health propaganda have been very limited. That defect has been remedied by the Public Health Act of 1925 which has just passed through Parliament, and which gives pretty wide powers to all local authorities to undertake education and progaganda in relation to the prevention and treatment of any disease." (Q. 24,143.) If our conclusion is accepted, it is obvious that still another branch of the work of the Committees would disappear.

Deposit Contributors and Navy, Army and Air Force Fund Members.

392. Lastly, we have to consider the work done by the Committees in connexion with the cash benefits of deposit contributors and members of the Navy, Army and Air Force Insurance Fund. This is the merest routine (*Kinnear* and *Brock*, Q. 23,981-90). A list of the deposit contributors of the area has

to be maintained, but the accounts are all kept by the Central Department and the calculations of the benefit due are also made there.

393. Similarly, in connexion with the administration of the benefits of the members of the Navy, Army and Air Force Insurance Fund, there is nothing that in fact calls for control by a large body of the type of an Insurance Committee.

Points from the Evidence.

394. With this review of the work of Insurance Committees before us we may now turn to what witnesses have to say on the matter.

395. Taking first the evidence which we received from certain of the Insurance Committees themselves, we were informed by the Coventry Insurance Committee (App. XXXIII, 30; Q. 12,240, 12,226-12,273, 12,305-12,316) that they had no wish to perpetuate these bodies as they are at present constituted and with their present limited functions, but suggest that "the Insurance Committees' current organisation is such that it can immediately and with considerable economy be utilised for extended administrative work, or brought into organic relationship with the local authority." The Cheshire Insurance Committee (App. XXXIV B, 40-50; Q. 12,454, 12, 457-12,458, 12,513) state that the Insurance Committee is truly representative of local interests, and feel that "to scrap the machinery of Insurance Committees or to make it a subsidiary part of a greater machine would be disastrous to insured persons," and they call for the continuance and enlargement of their duties. The Leicestershire Insurance Committee (Q. 12,663-12,665) maintain that the Committees are in close touch with insured persons and are familiar with local conditions, and they express the opinion that the District Councils and County Councils would not be prepared to take over the work as they are already overburdened. The view expressed by the British Medical Association (App. XLVII, 46-47) is that "the local administration of all health services should be in the hands of a local authority established *ad hoc*," and the Association suggest that a unification of medical services such as they contemplate would involve the disappearance, as such, of Insurance Committees. The Retail Pharmacists' Union (App. LXV, 82; Q. 18,091) recommend the retention of the present method of administering medical benefit through Insurance Committees. Mr. Alban Gordon, who speaks from some practical experience, as he was Clerk to the Coventry Insurance Committee in 1912, a member of the London Insurance Committee from 1913 to 1921, and a member of the Brighton Insurance Committee during 1924 and 1925, states: "The continued existence of Insurance Committees with their present

limitations is, except for one single function, a pure farce. That exception is the Medical Service Sub-Committee, which performs useful work. Apart from this, however, it is impossible to see anything whatever for the Insurance Committees to do that could not be equally well accomplished by a subordinate official in the local Public Health Office" (App. XIII, 21-22). He contends that the insured persons' representatives on the Committees are, in fact, nominated by the larger Approved Societies, and that there is thus no real representation of insured persons. (*See also* Q. 7452, 7725, 7766-7768, 7775-7785.) Dr. Harry Roberts gave evidence on similar lines. He says (Q. 16,120) that he "would like to see Insurance Committees either abolished or, at least, their constitution entirely altered, because they are now but another name for Approved Societies. For all practical purposes they are the chairmen and secretaries of the Approved Societies, which was not the original purpose of the Act The insured person is not represented on them in any way whatever." The Society of Medical Officers of Health (App. LVI, 7; Q. 16,941, 17,100-17,101), while admitting that Insurance Committees "have done well according to their abilities and opportunities," state that the Committees have certain general public duties, but have failed to be efficient instruments in the promotion of better health conditions. The Society think that "Insurance Committees are, as separate bodies corporate, no longer required. Their duties would be more efficiently carried out by the local health authority . . ." Mr. Torrance giving evidence on behalf of the Ancient Order of Foresters (Q. 4308-4309) states that Insurance Committees do not, under present conditions, justify their existence. The Hearts of Oak Benefit Society (App. IV, 285-293) suggest the retention of the Insurance Committees and would regret the loss of the experience gained in matters relating to medical benefit during the last 13 years. The National Conference of Industrial Assurance Approved Societies (App. VI, 26; Q. 5448-5449), the Manchester Unity of Oddfellows (Q. 6053-6056) and the Rational Association Friendly Society (App. IX, 34; Q. 6651-6653) also support the retention of Insurance Committees. The National Association of Trade Union Approved Societies (App. XCII, 151-156; Q. 22,077-22,078) favour the formation of a committee of each local authority with certain representative persons co-opted to undertake the local administration of medical benefit. The evidence of Sir Wm. Glyn Jones (App. CVI; Q. 24,398-24,532) indicates the difficulties which hamper the work of Insurance Committees in their administration of medical benefit, and which, in his view, make it impossible to expand the scope of that benefit whilst its administration is in their hands. In conclusion, we may refer to the evidence given on behalf of the Ministry of Health by Mr. Brock (Q. 23,974-23,990), who states that "the duties devolving upon Insurance Committees (as distinguished

from their staffs) have become so limited in range that they do not offer sufficient attraction to public-spirited people, who could find much better scope for their energies on other local bodies. . . In some committees the members appointed by the County or County Borough Councils really form the only section with much experience of public administration." He adds: "They really have so little to do except disciplinary work, which is mostly done by the Medical Service Sub-Committee. On the other hand, if you give them more work to do, say, an extension of their general health duties, you bring them into competition with the other local health authorities" (Q. 23,975). We may quote also the following question and answers: "Do you consider that the Insurance Committees perform an essential service in regard to the benefits of deposit contributors that could not be otherwise arranged for?"—(*Sir Walter Kinnear*): "No." (*Mr. Brock*): "I agree with Sir Walter" (Q. 23,982). "The position is very much the same with regard to the Navy and Army Insurance Fund." (*Kinnear*; Q. 23,985). "We think a transfer of the powers and duties of Insurance Committees to the appropriate committees of the County and County Borough Councils would have the great advantage of being a step towards the co-ordination of all local health functions which is generally recognised as the logical corollary of the co-ordination of central health functions in the Ministry of Health. It would certainly facilitate co-ordination between Insurance and other Public Health services, and it would secure the independent expert advice of the medical officer of health and other medical officers of the Councils . . . . Whatever Committee" (i.e., of the County and County Borough Councils) "is charged with these duties, it is desirable that it should contain a strong co-opted element including adequate representation of the doctors." (*Brock*, Q. 23,991.)

Transfer of Powers and Duties to Local Authorities.

396. The conclusion we come to, then, is that Insurance Committees should be abolished, and that their work, very much in its present form, pending any radical remodelling and unification of the Health Services, should be handed over to committees of the appropriate Local Authorities with possibly a co-opted element. We do not enter into any details as to what is the appropriate local authority, as this question is dependent on the results of the deliberations of the Royal Commission on Local Government now sitting. Until the lines on which the general framework of the local government of the country is to be remodelled are known, any specific recommendations would be useless. If our recommendation in this matter is adopted, we think it may safely be assumed that

provision would be made for the absorption of the staffs of the present Insurance Committees.

SECTION E.—DEPOSIT CONTRIBUTORS.

397. We now come to a problem which has exercised the minds of the administrators of the Insurance Scheme ever since its inception—that of the deposit contributors. This class was established at the institution of National Health Insurance as a temporary arrangement for the accommodation of those insured persons who would not, or could not, join Approved Societies. The arrangements were to be reviewed in three years. The difficulties of finding a solution of this problem have been so great and the arrangements in their present form have worked with such a considerable degree of success, that the Deposit Contributors Fund still remains an integral part of the Scheme. The present membership of the deposit contributor class is about 240,000 persons, i.e., about 1½ per cent. of the total number of insured persons.

398. The following table shows the number of deposit contributors in England in November, 1924, classified in accordance with the years in which they became deposit contributors :—

Year of becoming a Deposit Contributor.	Men.		Women.		Men and Women (combined).	
	Number.	Per-centage.	Number.	Per-centage.	Number.	Per-centage.
1912	13,663	9·01	6,007	7·03	19,670	8·30
1913	1,999	1·32	1,191	1·39	3,190	1·35
1914	2,127	1·40	1,099	1·29	3,226	1·36
1915	3,959	2·61	2,320	2·71	6,279	2·65
1916	3,478	2·29	3,450	4·04	6,928	2·92
1917	4,117	2·72	4,549	5·32	8,666	3·65
1918	4,206	2·77	4,203	4·92	8,409	3·55
1919	19,495	12·85	4,018	4·70	23,513	9·92
1920	11,938	7·89	6,694	7·83	18,632	7·86
1921	11,958	7·89	8,131	9·51	20,089	8·47
1922	20,358	13·42	12,117	14·18	32,475	13·70
1923	31,204	20·58	18,337	21·46	49,541	20·89
1924 (to Nov.)	23,128	15·25	13,344	15·61	36,472	15·38
Totals ...	151,630	100·00	85,460	100·00	237,090	100·00

The table shows :—

(1) That only 8·3 per cent. of the present total membership became deposit contributors in 1912.

(2) That for the succeeeding six years the corresponding figure is extremely low, and even for 1918 it is under 4 per cent.

(3) That approximately half the present total of 237,090 joined the class within the last three years.

The following table shows the number of deposit contributors at various points since the beginning, and the exits from this class in the periods stated :—

EXITS FROM DEPOSIT CONTRIBUTORS FUND.

Year	Transfers to Approved Societies.	Exits for other reasons.	Total Exits.	No. of Deposit Contributors at end of year.
1912–16	265,736	229,512	495,248	300,470
1917	61,418	15,715	77,133	337,048
1918	55,181	71,623	126,804	349,394
1919	43,601	75,487	119,088	416,926
1920	74,432	135,184	209,616	305,785
1921	63,603	109,810	173,413	247,122
1922	44,870	83,731	128,601	245.019
1923	43,428	77,374	120,802	238,547
1924 (to 1.11.24) ...	43,288	60,396	103,684	237,090

It will be seen :—

(1) That apart from the inflation in the War years due to many persons coming into insurance temporarily for various reasons, the numbers appear to be falling.

(2) That the exits during each of the last three years are somewhat under half the total number in the class at the end of the year.

(3) That a large proportion of the total exits represent transfers to Approved Societies.

399. These tables appear to show that the Deposit Contributors class is, in large part, in a fluid state and that the permanent residue is not considerable. We understand that from the results of an inquiry on a restricted scale which was made in 1913, supplemented by the experience of the last 13 years of administration, deposit contributors may be fairly accurately classified as follows :—

(1) persons suitable for Society membership who have not yet chosen a Society, but will eventually do so ;

(2) persons who through ignorance or indifference, or personal objections, neglect or refuse to apply for Society membership ;

(3) persons temporarily, or intermittently employed, or not expecting to remain permanently in this country ;

(4) persons expelled from Societies and unable to obtain admission to another Society ;

(5) persons in ill-health who are unable to obtain admission to a Society.

400. It is not, we understand, possible to say in what proportions deposit contributors fall into these classes but the first class is the most numerous. The Ministry of Health informed us (App. I, A. 100) that "a majority of deposit contributors are in good health and would have no difficulty in joining a Society." We were also informed by the Scottish Board of Health (App. II, A. 28) that "an investigation of a sample of deposit contributors in Scotland disclosed that only 8 per cent. had been refused admission by Societies and that more than two-thirds had failed to join Societies by reason of neglect or ignorance." Contrary to original expectations, it is clear, therefore, that the class is not made up almost entirely of "bad lives," and that so far as health is concerned the majority are eligible for Society membership. The fact that certain Societies have offered to take over the whole of the deposit contributors and that other Societies have pressed for allocation of the whole of the deposit contributor class among Societies, confirms this view.

401. We are informed (Ministry of Health, App. I, A, 97, *Kinnear*, Q. 384) that though not engaging in direct propaganda among deposit contributors, the Department make use of every reasonable opportunity of impressing on them the desirability in their own interests of seeking admission to a Society. Thus, a reasoned explanation and exhortation is given first place in the leaflet of instructions sent to every deposit contributor; all contribution cards issued at Post Offices have a note on the subject; and advice to join a Society is printed on every Record Card issued to a deposit contributor.

402. It has to be borne in mind that, while the payment of contributions is compulsory, the further steps to be taken, e.g., the choice of an Approved Society and the making of an application for membership, call for voluntary action on the part of the insured person. Not all insured persons are able or willing to take the necessary steps within any time which may be officially prescribed, though they may have no objection to the underlying principle. They become deposit contributors for a time, but afterwards choose and join Societies.

Points from the Evidence.

403. The evidence which has been placed before us indicates the difficulty of the problem, and suggests varying solutions. For example, the Hearts of Oak Benefit Society suggest (App. IV, 89-107; Q. 2926-3025) the abolition of the class and compulsory allocation among Societies. The National Conference of Industrial Assurance Approved Societies (App. VI, 14; Q. 4874-4892, 4908-4909) would abolish the class and allocate members to Societies with increased reserve values for impaired lives. They would, however, offer no objection to the institution of a State Society. The Ancient Order of Foresters

(Q. 4383) object to the formation of a State Society, and hold that the retention of the class for the residuum is desirable. The Manchester Unity Order of Oddfellows (App. VII, 64-66; Q. 5847-5848, 5851-5855, 5882-5888) suggest the formation of a special Deposit Contributors Society. The Independent Order of Rechabites (Q. 6116) and the Joint Committee of Approved Societies (Q. 8243) would abolish the class and would accept compulsory allocation to Societies, but would not give up the right of expulsion. The Prudential Approved Societies (Q. 9686) would have no objection to the formation of a State Society.

404. The National Federation of Rural Approved Societies (App. XXIX, 16; Q. 11,716-11,732) suggest that those deposit contributors who are unable to join an Approved Society by reason of the state of their health should be entitled to benefits at such rates as may be found actuarially possible, but not exceeding the normal rates, and that for this purpose the accrued interest on the Deposit Contributors Fund and the balances in the accounts of those members who cease insurance should be available after any member of the type referred to has exhausted the amount standing to his individual credit.

Question of Compulsory Allocation.

405. We have considered the proposal for compulsory allocation of the deposit contributors among Approved Societies, but are convinced that such a scheme, however attractive in theory, would fail on the practical side. It would be expensive and contentious; it would provide a difficult and continuing problem. It might involve renunciation by all Societies of their right to reject an applicant or expel a member. Some Societies would be willing to make this sacrifice, but others, particularly those identified with special interests (such as temperance), are unwilling, and it would be difficult to require such Societies to renounce the essential basis of their association. Moreover, compulsory allocation would tend to destroy the fundamental conception of Approved Societies as voluntary associations of insured persons, and the Department ought not to be a party to forcing unwilling members on unwilling Societies, especially as, in the case of small units (which could not be ignored), the allocation of one bad life might adversely affect the interests of all the members. Even if the difficulties as regards Approved Societies were surmounted, the still greater difficulties of the allocation authorities would remain, whether these were central or local bodies. At the cost of much labour and expense the Department could supply classified lists of existing deposit contributors, but while the allocation authorities deliberated, new cases would be arising at a rate not far short of 50,000 every six months, and these also would require to be sorted and listed; while provision would have to be made for the payment of benefits becoming due before completion of allocation, and

a list of allocations maintained lest a contributor should be allocated more than once—for some persons would refuse to recognise the allocation and would continue, for a time, at least, to send their cards to the Department. It will be understood that preliminary correspondence is often necessary before the position in insurance of persons surrendering cards, presumably as deposit contributors, can be determined. This is referred to in paragraph 99 of Section A of Appendix I to the Minutes of Evidence. Some form of official " Clearing House " would be inevitable.

406. No Society or other body has at any time put forward a practical scheme for allocating deposit contributors, and we are informed that, despite prolonged and careful examination, the Department has been unable, so far, to devise one which would give satisfaction to insured persons, to Approved Societies, or to those who would be required to administer it. Further, having regard to the consideration of the shortness of the average insurance life of deposit contributors, as such, it is doubtful whether, weighing the cost against the probable results, the adoption of an allocation system could be justified, even if a satisfactory practical scheme were forthcoming. In substance, there would be elaborate machinery for allocating insured persons, many of whom would, in any event, without the intervention of the Department, allocate themselves within a short space of time.

407. We have dealt above with the difficulties of allocation chiefly from the point of view of the Department. There is, however, another aspect which must be examined. Approved Societies are bodies formed by voluntary effort and, as a rule, have close relations in each case with some particular form of social activity. Some, for instance, are Friendly Societies, several of which require special qualifications, e.g., total abstinence, for membership. Others are, or exist in connexion with, trade unions; yet others are connected with organisations engaged in industrial assurance; while a considerable number have been established for the employees of particular firms or commercial companies. The insured person who cannot find one Society to suit him among the diverse organisations which open their doors to him is doubtless hypercritical, but his susceptibilities are nevertheless so far to be respected that he ought not to be forced, by Departmental allocation, into any particular Society, regardless of his views upon the subject. The fact is that, if every insured person is to be compelled to be a member of some Society, a Society must be established by the State to receive those persons who object to taking up membership in any of the voluntary bodies, and who, if they were allotted against their will, could render the whole scheme of insurance inoperative, so far as they were concerned, by declining to surrender the cards containing the evidence of the contributions which had been exacted from them. There are,

however, strong objections to the establishment of a special State Society for those insured persons who do not choose to join one of the existing Approved Societies. Such a Society would be in competition with Approved Societies and would offer benefits which, even if restricted, would almost inevitably have to be guaranteed by the Government. It would be a departure on a large scale from the principle of self-governing Societies self-contained financially, which is the essence of the National Health Insurance Scheme.

General Considerations.

408. The fact that the present scheme is working smoothly and meeting the real problem of insured persons on their way to Approved Societies or of those who only expect to be in insurance for a short time, goes far, in our view, to dispose of the criticisms directed against its retention. This is specially so since the additional benefit schemes of Approved Societies have come into operation, for they have offered a marked and increased inducement to transfer from the Fund to Societies. So far, indeed, as the types of person referred to in (1), (2), (3) and (4) of paragraph 399 above are concerned, we see no reason whatever to alter the system. Insured persons of these types will always be with us. The Deposit Contributors Fund provides for them as convenient an arrangement as can be made. They can have no grievance against the system since it is open to them at any time to apply for admission to one or other of the numerous Approved Societies of all types. The persons in class (4) might, indeed, have difficulty in getting into a Society, but their number is so small and their position is so much due to their own default that we do not think they merit any special consideration.

409. When, however, we come to class (5)—those persons in ill health who are unable to obtain admission to a Society—we feel that something more than the meagre cash benefits of the Deposit Contributors Fund should be provided. We feel that in a scheme of National Health Insurance under which compulsory contributions are exacted, the continued existence of this class, under its present conditions, invites serious criticism. We direct attention to the evidence submitted by Sir Walter Kinnear on behalf of the Ministry of Health in Q. 23,616-23,646; and also to the suggestions, already referred to, made by the National Federation of Rural Approved Societies in paragraph 16 of Appendix XXIX. The recommendations which we make are generally on the same lines as are suggested in the evidence in question.

Proposed Insurance Section.

410. We propose that two sections of the Deposit Contributors Fund should be formed—an "Individual Account Section" on

the present basis, and an "Insurance Section" on a mutual basis. The latter section would provide for the persons in ill health who prove to the satisfaction of the Department that they are unable to obtain admission to an Approved Society, the former for all the rest. In respect of the former class, the only change we recommend is that the right of a deposit contributor on death or emigration to half the balance to his credit should be abolished, and that those half-balances be dealt with as described below.

411. In the Insurance Section we think that the normal benefits of the Act (but no additional benefits) should be paid for a certain period of years, and that if, at the end of that period a valuation reveals a deficiency, the position should be met out of the resources available under the Act in the manner explained in paragraph 413 below. The funds for the Insurance Section should, we think, be derived from four sources—the contributions of the members of the Section; the appropriate State grants; the balances of the deposit contributors in the Individual Account Section released on death or emigration; and the accruing interest on the whole Fund, which, we understand, runs to about £40,000 a year. It is difficult to say whether the total of these resources would sustain the Fund in view of the uncertainty as to the number in the Insurance Section. We believe, however, that that number would be so small that the experiment is worth trying.

412. Some form of test for admission to the Insurance Section would be necessary. A test of the kind we contemplate already exists in the case of the Navy, Army and Air Force Insurance Fund, namely, rejection by one Society on the grounds of health. It might be desirable to require rejection by two or even three Societies of different types before admission to the Section was allowed and also to provide for a periodical review by requiring the members to submit further evidence of the same kind at intervals.

413. As the Insurance Section would have the character of an Approved Society we think that the usual deductions for the purposes of reserve values, the Contingencies Fund, and the Central Fund should be made from the contributions of its members and that if there is a deficiency on valuation of the Section, the normal provisions for recourse to the Contingencies Fund and Central Fund should have effect. In this connexion we refer to the evidence of Sir Walter Kinnear. (Q. 23,643-23,646.)

414. We have recommended above that the balances released on death or emigration and the accruing interest on the whole Deposit Contributors Fund should be credited to the Insurance Section. In respect of these special sources of revenue, therefore, the Section would differ from the ordinary Approved Society. It is impossible to forecast what the position of the

Section is likely to be on valuation, but it is possible that by reason of these exceptional revenues a surplus might be shown. In that event we consider that in so far as such surplus is attributable to the additional sources of revenue to which we have just referred, it should be paid into the Central Fund.

415. So far as the members of the Individual Account Section are concerned, it would be desirable that the Department should continue the efforts to induce these members to transfer to Societies.

416. It may be suggested that some Societies would object to this system as instituting competition by a State Society. We do not, however, think that such objections could be seriously sustained if the arrangements took the restricted form we have outlined. Further, we may recall that the witnesses representing the Prudential Approved Societies which contain about 3,200,000 members stated in evidence that they had no objection to a State Society. In any case the reply to Societies is clear. If they are willing to admit any particular deposit contributor the problem is solved. The member would be so admitted or would be transferred from the Insurance Section to the Individual Account Section of the Fund.

417. We understand that there is interest accumulated by the Fund since 1912 amounting to about £400,000 and that there is no statutory authority for the disposal of this sum. We think that in any amendment of the Act authority should be given for passing the accumulation up to the date of the institution of the new system which we propose, to the Reserve Suspense Fund, where it would be available for the redemption of reserve values.

SECTION F.—THE INSURANCE PRACTITIONERS' CONTRACT.

418. Among the important problems of the Insurance Scheme is the administrative relationship of the medical profession to the Central Department and to the Insurance Committees. Two important elements in this appear to call for discussion here—the method and scale of remuneration of the insurance practitioners and the procedure under which complaints against them are determined. As to the first, there has not been much evidence in criticism of the present rate of remuneration though alternatives to the capitation method of payment have been suggested. As to the second, we have received representations from the medical bodies to the effect that the Regulations press rather harshly on the defendants in such cases.

419. No one is likely to under-estimate the importance of these two questions when it is remembered that 15,000 doctors and 15 million insured persons are involved. The success or failure

of medical benefit must depend to a very great extent upon the cordial acceptance of the financial terms of the contract by the medical profession and upon their approval of the Regulations under which their daily duty towards the insured persons is carried on. We will accordingly devote some space to a review of these matters.

The Method and Scale of Remuneration.

420. A full account of the course of the arrangements for remunerating the insurance practitioners since the inception of the Scheme up to the present date will be found in paras. 105 to 142 of Section C of Appendix I to the Minutes of Evidence. The earlier parts of this are now mainly of historical interest but we may describe briefly the arrangements since the beginning of 1920, when the so-called "floating sixpence" was abolished, with the consequence that the discussion of the capitation fee became simplified by the elimination of the drug factor. On that footing the Insurance Acts Committee of the British Medical Association, acting on behalf of the general body of insurance practitioners, claimed that the fee should be 13*s.* 6*d.* The Minister, acting for the Insurance Committees, who, in fact, make the individual contracts, did not accept this figure but offered 11*s.* The difference was referred to arbitrators who determined the latter figure and this remained in force from 1st January, 1920, to the end of 1921. During 1922 and 1923, a reduction to 9*s.* 6*d.* was accepted by the Profession on the ground of the urgent necessity for national economy. On a further proposal by the Minister for the reduction of the fee to 8*s.* 6*d.* for three years, or 8*s.* for five years, there was again resort to arbitration with the result that 9*s.* was determined for the three years ending 31st December, 1926.

421. New terms must be settled before the end of 1926 and, obviously, must take account of any change (whether resulting from our recommendations or otherwise) in the nature and volume of the services to be rendered by the practitioners under their contract.

422. Although the Minister's offer was for less, and the doctor's claim for more than was, in fact, awarded at the last arbitration, and although the Approved Societies made at the time very strong representations for a more substantial reduction of the fee, the award appears to have given, on the whole, as much satisfaction as is possible in such circumstances. In assessing the effect of the award upon the actual remuneration of practitioners with lists of various sizes, the existence of the large mileage grants must be kept in mind. These provide substantial additions to the capitation income of many rural practitioners. An account of the scale and methods of alloca-

tion of these grants is given in paragraphs 163 to 169 of Appendix I, Section C.

Points from the Evidence.

423. We may now conveniently give some extracts from the evidence submitted to us on these matters.

424. Dr. Smith Whitaker, in reply to a suggestion that the figure should be based very largely on the amount of the remuneration the doctor received in pre-war days, with a reasonable loading for the rise in the cost of living, remarked, "Is the question not really this, what does the general practitioner, as a class, consider the value of his time and skill? Our service has to compete with other sources of income that are open to him, and in the result it is a kind of balance of the inducements to different doctors throughout the country." (Q. 1447.) He added, that it was difficult to say whether effective comparisons could be made with other professions in this matter. (Q. 1448.)

425. Mr. Alban Gordon, in referring to the financing of the extensions of medical benefit, refers to "the present method of remuneration of panel practitioners, which is not only, in my opinion, generous in itself but is unduly generous in the case of the urban practitioner possessing a large panel" (App. XIII, 56). In answer to Q. 7834, he states, "I think the present system . . . . is bound to be either unjust to those who have too little work or unduly generous to those who have a great deal."

426. The British Medical Association state that they are "convinced that the capitation fee is still too low . . . . ." and that "the extra amount allowed for rural conditions requires reconsideration." (App. XLVII, 59.) We may refer also to App. XLVIII, 60-62, where the views of the Medical Practitioners' Union are set forth.

Considerations as to Future Negotiations.

427. The immediate problem arising from the above considerations and from the course of the evidence falls into two parts: (1) Assuming the same services are given, has any change in the economic or other circumstances arisen since 1923 to justify a variation of the capitation fee? (2) If extended services are given, what is the fair reward for them?

428. We do not think that it falls within our province to make a recommendation under either head. This is a subject which clearly must be discussed between the Minister and the Medical Profession in settling the terms of service to take effect at January next. The point to which we direct attention is the frequency of the review of the rate of remuneration. On this

we would emphasise the need for the desirability of fixing the figure over a reasonable period of years, so as to give to all parties a settled financial basis for their relations. We cannot think that periodical disputes over remuneration are good, either for the Profession or for the professional work. Further, new entrants to the Profession, and persons contemplating the long course of studies now required, ought to be in a position to assess the rewards of the Profession for a period of years ahead. We cannot but think that if some such stability were assured, the advantages would be very great. And as prices now seem to have reached a fairly stable level, there is clearly the opportunity for some settlement, valid over a period of years.

429. If the question of the capitation fee is to be re-opened, it appears to us that there are two distinct principles which may be considered. The Ministry may proceed on past history and adjust the fee according to the cost of living and the rates in force in the contract practices of pre-insurance days. We need only refer in passing to the difficulties attendant upon this method—the limited scope of contract practice, its peculiar nature, the equipoise of the large volume of private practice, which has now in considerable measure disappeared, and so on. The other method—and it is one on which the British Medical Association has laid stress in its evidence before us—is to assess the present market value of the services under the contract, as measured by the rewards secured for similar services in private practice, and the inducements necessary to secure a sufficient flow of properly qualified entrants into insurance practice. We feel that it is a little difficult to apply this criterion, as private practice among the wage-earning population has been so drastically curtailed by the Insurance Scheme. Still the dependants remain, and probably there are sufficient data available in this way to give a measure of market value.

430. As we have indicated, we do not feel that it is for us to recommend a definite figure. We have had little evidence on the point, and, indeed, one of the two parties principally concerned, namely, the British Medical Association, deliberately refrained from submitting arguments, on the ground that the problem must be dealt with later by the Department when our general recommendations had been received and considered. (App. XLVII, 58-59.)

Alternatives to the Capitation Method.

431. We may direct attention, however, to the method of calculating the remuneration for the general practitioner service. We come unhesitatingly to the conclusion that the capitation basis should remain. We have heard arguments in favour of the attendance system, the case value system, and even the full-time salaried system. But the overwhelming weight of evidence,

especially that of the British Medical Association, has been for the capitation method ; and we cannot believe that a system that has been in successful operation in practically all parts of the country for 13 years can be open to serious criticism. It embodies the salutary principle that it is to the interest of the doctor that his patients should remain in good health, or be restored to good health as quickly as possible. It directs attention to the preventive side of the work at an early stage. We have had no evidence to show that the system has induced members of the profession to scamp their duty to their patients or to treat them with want of sympathy or attention. We have received evidence from those in favour of the attendance system which is operative only in Manchester and Salford ; but we have come to the conclusion that that system has in practice become so hedged about with restrictions to prevent over-attendance and with adjustments to meet the general interests of the whole body of doctors working it, that —apart from the complicated nature of the machinery which it necessitates and the inexactness of the results attained—it really differs in essence very little from the capitation system. As to the case value system, we refer to Appendix XCI for a description of this ; but we do not feel that at this stage in the development of insurance practice it could or should be introduced as a universally obligatory system. We need not go into the arguments for or against a salaried service. The fact that the profession is almost unanimously against this method is sufficient to make it impracticable. Mr. Brock's reply to a question on a somewhat larger issue is equally applicable here. " No public medical service embracing four-fifths of the population and requiring the co-operation of the great majority of general practitioners could be effectively worked unless the remuneration and conditions of service were such as to be acceptable to the majority of the profession." (Q. 24,178.)

432. To one other suggested modification in the method of remunerating insurance practitioners it is perhaps desirable to refer at somewhat greater length as it involves a point of some novelty. The National Federation of Rural Approved Societies recommend that doctors be rumunerated for their services according to a graduated scale, instead of by a uniform capitation payment as at present (App. XXIX, 11-13). Under such an arrangement it is suggested that the highest rate should be paid in respect of the first 500 insured persons accepted, a lower rate or rates being paid in respect of the remainder. In examination it was made clear that this proposal was put forward primarily on the alleged ground that a list of 1,000 does not involve twice as much time and expense as a list of 500. A system of remuneration, in which the capitation fee decreased at successive stages with an increase in the number of insured persons accepted, would obviously operate to discourage the existence of unduly large lists, and it might be advocated on these

grounds. We were assured, however, that while this obvious consequence was present in the minds of those who advocated the scheme, this consideration did not furnish the justification for the proposal, which was defended on the ground of its own inherent equity (Q. 11,612-11,617). We consider that if the existence of large lists is still productive of evils (as it indubitably was in the earlier days of the Health Insurance Scheme) such an indirect method of discouragement is not to be commended, and that preference should be given to the method (which has in fact been adopted) of definitely limiting the number of insured persons whom a doctor may accept. It is only right to add that we have had no evidence to show that under present conditions any evils result from the existence of lists which can be regarded as unduly large.

433. Turning to the merits of the proposal, it can hardly be contended, and it was not in fact contended by Mr. Wood, who appeared for the National Federation of Rural Approved Societies, that the work involved increases otherwise than proportionately with the number of insured persons accepted. The only ground then on which the scheme can be advocated is the assumed saving in time and overhead charges which comes with an enlarged practice. In neither case do we consider that, so far as Health Insurance practice is concerned, there is a law of diminishing cost so markedly operative as to make it expedient to grade the remuneration of practitioners in the manner suggested. The fact that the attendance given under the Health Insurance Act is only a part of most doctors' practices renders the reasoning of the Federation on this point inadmissible. A doctor with a small insurance practice may yet have a large practice otherwise, and may enjoy all the economies of time and of overhead expenses inherent in large scale practices. The doctor should receive remuneration primarily for work done, and only secondarily for time taken; and when in exceptional circumstances the time involved becomes a factor demanding consideration, the appropriate method of meeting the circumstances is by the grant of a mileage allowance. Apart from these fundamental difficulties the scheme would, we are satisfied, tend to many anomalous results; it is unlikely that it would commend itself to the Medical Profession as a body, and we are therefore unable to recommend its adoption.

The Complaints Machinery.

434. We now turn to the more difficult question of the machinery for determining complaints against Insurance practitioners.

435. We have given very careful attention to the criticisms advanced by representatives of the medical profession on certain aspects of the present Regulations affecting the obligations of

insurance practitioners and on the present procedure for the investigation of complaints against practitioners.

436. The procedure for dealing with complaints is described in Appendix I, C, 40-56. The criticisms will be found in Appendix XLVII, 35-43, Q. 15,213-15,220 and Appendix XLVIII, 43 and 47, Q. 15,504-15,511, 15,519-15,627, 15,682-15,712, 15,715-15,728.

437. We refer particularly to the lengthy evidence which the Medical Practitioners' Union App. XLVIII, 43 and 47; Q. 15,504-15,511 and 15,519-15,627) submitted on the subject of the complaints procedure. Much of this evidence is directed to similar points to those put forward by the British Medical Association, though in a more emphatic form. We deal with the whole subject on its general bearings below. We would, however, remark here that the privileged position, which the Medical Practitioners' Union urge should be granted to practitioners under the complaints procedure, is one which we do not think could be conceded on any grounds of public policy; nor do we think that the witnesses of the Union were able in oral examination to sustain effectively the demands which they put forward.

438. The witnesses appearing on behalf of the British Medical Association classified the conditions of service of insurance practitioners in two categories—and we appreciate the importance of the distinction—namely, conditions affecting the professional relation between doctor and patient and conditions relating to the fulfilment of the doctor's contractual obligation to keep records and to perform other similar duties specified in his agreement and the Terms of Service. (App. XLVII, 40.) As to the latter category, it is admitted that in cases where the non-fulfilment of the obligation is established, disciplinary action is justifiable and, indeed, inevitable, though certain changes are advocated in the machinery of investigation. But it is suggested that questions affecting the relations of doctor and patient should not be made the subject of disciplinary procedure, on the ground that, with the present unrestricted choice of doctor, the patient has an effective remedy in his own hands. This contention we find ourselves wholly unable to accept, first, because we are not satisfied that the freedom of choice of insured persons can be relied upon as sufficient to produce the requisite result, and secondly, because the entire abrogation of the Minister's responsibility for the efficiency of the service rendered by insurance practitioners to their insured patients is, in our view, inconsistent with the fulfilment of the duties placed on the Minister by the Health Insurance Act, and with sound principles of administration of a publicly provided service.

439. The theory that competition for patients is sufficient by itself to secure a satisfactory service, clearly does not apply in those areas in which there is, in fact, no freedom of choice, and where, therefore, no competition exists. In many rural and semi-rural areas the geographical distribution of doctors is such that insured people have no real choice, while at the other end of the scale there are congested urban areas in which the number of available doctors is so limited that they want no more patients than they have already. But even in the areas in which there is a real freedom of choice, we see no sufficient grounds for assuming that the right of transfer would be by itself a sufficient protection to the patient. Before the Act came into operation there was unlimited freedom of choice in urban areas, but it can hardly be contended that the resulting competition produced a satisfactory level of service in the poorer areas, which had become accustomed to a low standard of professional work.

440. Apart from the special difficulty of the rural areas and the more congested and less attractive urban areas, we are not convinced that it is fair to assume, as a general proposition, that patients who feel dissatisfied with their treatment will seek another doctor. We agree that a wise doctor will not seek to retain a patient who has lost faith in him, but it does not follow that a transfer is always made either pleasant or easy. In any case, the inertia of a large proportion of the insured population will operate to prevent persons from making a change, though they may have legitimate grounds for dissatisfaction. Even with free choice, the percentage of changes at any time is, relatively, small, and it would be too large an assumption to suppose that among the vast majority who do not change there are none who have good reason for wishing to do so.

441. Even were the insured person in a better position than we believe him to be for securing the efficient discharge of his insurance practitioner's duties towards him, we consider that to place upon him, in effect, the entire responsibility in this matter, would be fundamentally inconsistent with the whole scheme of medical benefit, under which the Insurance Committee is primarily responsible for securing efficiency of the medical service within its area, subject to the general responsibility of the Minister. We find nothing in the Act to justify excluding from the questions of efficiency of the service for which the Insurance Committee and the Minister are responsible questions of the kind which the British Medical Association desire to have excluded. If, therefore, such proposals were to be brought into operation, this could only be done, as it appears to us, through amending legislation which would be so inconsistent with accepted principles of public administration and Parliamentary responsibility that we cannot recommend imitation.

442. On questions of procedure for dealing with complaints against practitioners, the British Medical Association made certain suggestions for the alteration of the Regulations, and also formulated certain principles which they considered ought to be observed in the exercise of the powers possessed by the Minister under the present Regulations. The alterations of Regulations suggested were: (1) that all complaints against a practitioner should, in the first instance, be sent to the Chairman of the Local Medical Committee and the chief administrative medical officer of the Local Authority; (2) that only such cases as could not be settled by them with the acquiescence of both parties should proceed further; (3) that questions of general conduct, detrimental to the service, or of giving false certificates should be reported upon in the first instance by the Local Medical Committee; (4) that an appeal to the Courts should be possible not only on the ground of improper procedure as at present, but on the ground that the penalty inflicted was out of proportion to the offence; (5) that in the case of proposed removal from the service the practitioner should have the right of appeal to a duly constituted central professional committee, and that the Minister of Health, in cases where this right was exercised, should not be able to remove the practitioner from the service unless the central professional committee advised this course. (App. XLVII, 41.)

443. The first two of these proposals involve entrusting to a purely medical body the duty of considering whether the complaint against a practitioner should, or should not, be proceeded with. Such an arrangement appears to us highly undesirable, and we gather that it was not pressed by the witnesses who appeared on behalf of the Association (Q. 15,226). We are also not satisfied that there is any good reason for the exclusion of the lay element from the primary investigation of the class of cases referred to in (3).

444. The fourth proposal involves placing upon the Courts of Law the responsibility for deciding questions of a kind which, in our opinion, can be more appropriately decided by a Minister who is answerable to Parliament for the manner in which he exercises his discretion. The fifth proposal we are also unable to accept. We appreciate that removal from the medical list may be, and usually is, a very severe penalty, but it has to be remembered that the ground of removal is that the retention of the practitioner would be prejudicial to the efficiency of the medical service of the insured persons, and it would, in our judgment, be contrary to sound constitutional practice that the Minister's responsibility to Parliament for the maintenance of an efficient service should be delegated to an outside body, whether professional or otherwise.

445. The four principles which the Association submitted for our consideration, not as requiring alterations in the Regulations,

but as affecting the Minister's exercise of his powers under the existing Regulations were as follows : (1) that when a complaint has been dealt with by the bodies set up by the Regulations for this purpose there should not be a liability to have the whole matter re-opened by separate Departmental action either by the Ministry itself or by those bodies at the instigation of the Ministry; (2) that when the complaint has been made in one prescribed form penalties should not be inflicted in respect of offences not formally alleged or of offences which, if alleged, should have been formulated in a different prescribed way, and might have required a different line of defence; (3) that full consideration should be paid to the findings or recommendations of a committee (whether Medical Service Sub-Committee, or Inquiry Committee) which has itself investigated the details of the case, in mitigation of the heinousness of the misconduct even when proved; (4) that it is essential to draw a strict distinction between professional conduct in the attention given to a patient and the nature of the exact professional treatment given to the patient, and that the propriety of any particular method or line of treatment should not be made the subject of investigation in connexion with the insurance service. (App. XLVII, 42.)

446. The Association submitted these principles, we gather, as a result of their consideration of particular cases recently dealt with by the Ministry. Details of those cases were not placed before us, and we are not, therefore, in a position to express any opinion as to how far the action of the Ministry may be open to criticism in the directions indicated. Moreover, it is difficult to express an opinion on the validity of some of these propositions without reference to particular cases, since they are stated in a form which is capable of various interpretations, and a general assent or dissent might be misleading. As regards the first point, we understand that the question arose in connexion with a particular case which came before the Lord Chief Justice, when this precise point was one of those on which the action of the Minister was challenged, and the Lord Chief Justice held that the Minister's action was perfectly proper. As to the expediency, as distinct from the legality, of such action, it appears to us that much may depend on the circumstances of particular cases, and the matter was not placed before us by the Association in sufficient detail to enable us to express an opinion as to the cases in which such an exercise of the Minister's powers might, or might not, be entirely desirable.

447. The fourth point is the one which the witnesses of the Association stated that they regarded as gravest and most vital. (Q. 15,220.) This proposition also appears to be one to which an unqualified assent might be open to misinterpretation. We agree that where it appears that a practitioner has exercised his

judgment to the best of his ability, his professional skill having been, in the words of one of the witnesses, "carefully and properly given to the patient," the Minister should not go into the question whether the line of treatment which was adopted is in accordance with any particular professional doctrine as to what is or is not the best line of treatment in such cases. From inquiries that we have thought it necessary to make we gather that the Minister accepts this view and would not regard it as part of his duty, when considering, as the Regulations require, whether a proper standard of treatment has been given, to enter into questions on which professional opinion might differ as to the efficacy of particular methods of diagnosis or treatment. This, however, is subject to the qualification stated, that the practitioner has, in fact, exercised his professional skill with reasonable care, and this appears to be a matter of which cognisance must be taken in the exercise of the Minister's disciplinary powers.

448. Evidence which we have heard in connexion with some of the foregoing points has brought to our notice one matter in respect of which the present practice appears to us to be open to criticism. We find that in cases in which representations have been heard by an Inquiry Committee, and the Minister, after considering their findings, has decided not to remove the practitioner from the Medical List, it is not unusual for grant to be withheld without any further hearing being allowed to the practitioner. (Q. 24,000.) It has been pointed out to us that this procedure is contemplated by the present Regulations, which were settled after consultation with the Insurance Acts Committee of the British Medical Association. But on the merits we are clearly of opinion that no grant should be withheld until the practitioner has been given an opportunity, if he wishes, of making oral representations and so of bringing to the Minister's notice any mitigating circumstances which in equity should be taken into consideration before any penalty is imposed. The task of the Inquiry Committee is to investigate definite allegations, and for the purpose of ascertaining the facts it is not relevant to consider whether there are extenuating circumstances. It follows, therefore, that if the Minister decides that the facts established by the Inquiry Committee do not warrant removal, but do appear to call for some lesser penalty, a new issue arises, and considerations may properly be taken into account which were not relevant to the major issue of removal from the List. For this reason we think that before any penalty other than removal is imposed, the doctor should be given an opportunity of a further hearing. If such an arrangement necessitates any alteration of the existing Regulations, a point which appears doubtful (Q. 24,000), we recommend that the necessary amendment should be made at the first convenient opportunity; but if the present Regulations

permit of it, we see no reason why this change in the practice of the Ministry should not be introduced at once.

449. It has been suggested to us by some witnesses, including those representing the Association of Insurance Committees, that an Insurance Committee should be able to make representations to the Minister against the inclusion of a doctor in the list of insurance practitioners where they consider that there are good reasons against such inclusion. (App. XXXVI, 37 and 39.) This proposal was strongly opposed by the witnesses from the British Medical Association. (Q. 15,214-15,215 and App. XLVII, 36.) The witnesses who gave evidence on behalf of the Ministry of Health regarded the suggestion as administratively inexpedient, if not impracticable, on the ground of the difficulty of establishing before a practitioner came on the List that his inclusion would be prejudicial to the efficiency of the Service. (Q. 23,999.) We are satisfied that it is inadvisable that the suggested change should be made

CHAPTER XIII.

MISCELLANEOUS QUESTIONS.

450. In this Chapter we propose to bring together and discuss a large number of suggestions which we have received in the course of our inquiry, directed towards various modifications in the existing scheme of National Health Insurance. In dealing with a measure so complex as the subject of our investigation has proved to be, bearing so intimately on the daily life of almost every member of the community in one way or another, and so closely related to every aspect of social legislation, it was only to be expected that there should be a vast number of proposals for amendment of one or other of the many sections of the Act or of the regulations made thereunder. Some of these proposals are in their way directed to fundamental points of principle; a few may appear to relate rather to matters of administrative detail. In bringing them together for discussion in this Chapter we desire to guard ourselves against any suggested implication that these matters, being of a miscellaneous are therefore of an unimportant character. We have adopted this arrangement because the questions which we now propose to discuss do not fall naturally within the scope of any of the main sections into which we have divided our Report.

451. The subjects dealt with are classified under the following ten main headings:—

Section A.—Persons to be included in the Scheme.
,, B.—Payment of Contributions.
,, C.—Administration of the Cash Benefits.
,, D.—Special Classes of Insured Persons.
,, E.—Valuation of Societies and Provision of Additional Benefits.
,, F.—Extension and Alteration of the List of Additional Benefits.
,, G.—Limitation on Increases in Cash Benefits.
,, H.—Miscellaneous Questions affecting Approved Societies.
,, K.—Other Miscellaneous Questions.
,, L.—Audit of Accounts.

SECTION A.—PERSONS TO BE INCLUDED IN THE SCHEME.

Employed Contributors.

452. The classes of persons who, under the existing Scheme, are subject to compulsory insurance are set out in Part I of the First Schedule to the Act and include briefly persons between

the ages of 16 and 70 who are employed under a contract of service or apprenticeship. Part II of the same Schedule sets out the classes of employment which are excepted from insurance, of which the chief are :—

(1) Employment under the Crown or any Local Authority, or as a salaried official of a railway or other statutory company, provided in each case that the terms of service make provision during sickness at least as favourable as that made under the Act; and

(2) Employment of a non-manual character at a rate of remuneration exceeding £250 a year.

453. We were informed in evidence given on behalf of the Ministry of Health that there has been no serious demand for any extension of the classes who are required to be insured (*Kinnear*, Q. 28). We received, however, from other witnesses suggestions for the inclusion of boys and girls in employment below the present age limit of 16, and of those persons remaining in employment beyond the present higher age limit for insurance; and further, for the extension of the income limit for the insurance of non-manual workers from the present figure of £250 to £350 a year. The British Medical Association, on the other hand, put before us suggestions for a lower income limit, e.g., £150 a year, to be applicable to manual as well as non-manual workers as part of a larger proposal for the exclusion from medical benefit of persons who (in the view of the Association) might reasonably be expected to make provision for themselves, and the inclusion of persons (particularly the dependants of insured persons) for whom medical treatment might properly be provided through a State scheme of insurance. On the general aspects of this proposal we have already commented in previous Chapters.

454. From the inception of the Scheme of National Health Insurance the age limits for the payment of contributions and title to sickness and disablement benefits have been 16 and 70. We have had little evidence in support of any change of these limits. The Scottish Miners' Federation suggested that logically boys and girls ought to come under the Health Insurance Scheme as soon as they begin to be employed, which is in many cases before they attain the age of 16 (Q. 6948-6949). The Lancashire and Cheshire Miners' Permanent Approved Society also were of opinion that it was desirable that insurance should begin with the commencement of employment, and gave as their chief argument in support of this view the undesirability of there being any gap in the provision for medical supervision of the health of boys and girls between the cessation of the provision made under the School Medical Service and the beginning of that under the National Health Insurance Scheme when they reach the age of 16. (App. XI, 4; Q. 7060-7064, 7093-7096, 7116-

7121). The National Association of Trade Union Approved Societies, having in view a closer co-ordination of Public Health and Medical Services, suggested that boys and girls should become compulsorily insured immediately upon taking up employment after leaving school. (App. XCII, 52-54; Q. 21,854.) The British Dental Association also call attention to the importance of continuous arrangements for dental treatment, and state that if such treatment were afforded as a statutory benefit for all insured persons, it would be most unfortunate that there should be an interval of about two years between leaving school and attaining the age of 16 during which the boy or girl would be left without any provision for obtaining dental treatment. (Q. 9227.)

455. On the other hand we are informed by Sir Walter Kinnear (Q. 37) that there is no real demand for the insurance of employed persons under the age of 16, and we have had no evidence that employers give any preference in employment to boys and girls under that age on the ground that insurance contributions are not payable in respect of them. The witnesses from the National Conference of Friendly Societies (App. XXVI, 10), the Manchester Unity of Oddfellows (Q. 5823-5824), and the Rational Association Friendly Society (Q. 6563-6564) were all of opinion that a lowering of the age limit was not desirable.

456. We do not consider that the arguments in favour of a lowering of the age limit for insurance are many or of great weight. The question of reducing the age limit in the case of Unemployment Insurance was recently considered by Parliament, and it was decided that the present limit of 16, as in the case of Health Insurance, should be retained. The determining factor in arriving at this decision was the trend of educational policy in this country which is in the direction of treating the period between 14 and 16 as one for which educational rather than industrial provision should be made. In so far as the normal school leaving age extends beyond 14, the gap in the provision of medical and dental supervision will become less, and in any case we do not consider that serious consequences need be feared as a result of this short interval if good habits have been inculcated as the result of the School Medical and Dental Services.

457. There are, moreover, serious practical objections to any lowering of the age limit for insurance. Such a change would either involve a special reduced scale of contributions and benefits at the ages of 14 to 16, causing considerable administrative difficulties, or it would necessitate the reconsideration of the financial structure of the Scheme.

458. As to the higher age limit of insurability, the position has been materially affected by the passing of the Widows', Orphans'

and Old Age Contributory Pensions Act. Under that Act from January, 1928, the higher age limit for the payment of contributions and for the title to sickness and disablement benefits under Health Insurance will be reduced from 70 to 65, at which age the title to contributory old age pensions will mature. We are satisfied that even where a person continues in employment after he has become entitled to an old age pension, it would be undesirable that he should be entitled, in addition to that pension, to receive sickness benefit when unable to work through illness. We note also with satisfaction that the Contributory Pensions Act provides that all persons who remain in insurance up to the age of 65 are to continue to be entitled to medical benefit for the rest of their lives. This provision sufficiently meets a case on which we received some evidence in the earlier stages of our inquiry, viz.: that of persons who cease employment before the age at which, under the Act as it now stands, the title to medical benefit for the rest of life is secured. We do not feel it necessary to make any recommendation with respect to the medical benefit of persons whose employment ceases before the age of 65, as it may be expected that such persons will now have a greater inducement to continue their insurance as voluntary contributors up to that age in order to preserve their valuable rights under the Contributory Pensions Act.

459. On the question of the income limit for insurability, we have carefully considered the proposal of the British Medical Association, that such a limit should be fixed for manual as well as non-manual workers. (App. XLVII, 8-18; Q. 14,689-14,708, 14,806-14,817, 14,914-14,944.) We are definitely of opinion that such a change would be undesirable. We think that the present principle which draws a firm distinction between manual and non-manual labour beyond a certain point is sound, inasmuch as the manual worker, whatever his earnings at any moment may be, is generally subject to economic conditions which render an insurance provision highly desirable. Where a manual worker is gaining a high rate of remuneration, it will generally be found that there is an element of instability of some kind in his employment. His work may be subject to broken time, or he may be seriously exposed to the graver evil of unemployment. Alternatively, his wage rate may be subject to considerable variation. In either case his rate of remuneration at any moment will furnish an unsatisfactory indication of what he may gain over a relatively lengthy period of time such as a year. There is the further point that in such cases the insured person might, on any income limit, be alternately, and with considerable frequency, entitled and disentitled to medical benefit. The only practicable method of dealing with this administrative difficulty would be to determine prospectively for a certain period

an insured person's title to benefit by reference to his financial position retrospectively, and it hardly requires to be pointed out that the adoption of such a solution might have the effect, and indeed would not infrequently have the effect, of granting an insured person medical benefit while his earnings were high, and withdrawing it in the subsequent period when his earnings might be reduced. This result would curiously defeat the whole purpose of the suggestion. Apart from such administrative difficulties we feel, moreover, that it would be a retrograde step to exclude from the Insurance Scheme, or even from the title to medical benefit under the Act, any section of the community which has hitherto been included and which has generally, so far as we have been able to gather, become not merely accustomed to insurance but appreciative of the benefits which it provides.

460. In the case of non-manual workers, the limit for insurability was raised in 1919 from £160 to £250 a year owing to the change in economic conditions. We are informed that the operation of the limit offers no more administrative difficulty than is to be expected (Kinnear Q. 36; Leishman Q. 1551). Our attention has been called to the fact that the income limit for non-manual workers has recently been increased in the Workmen's Compensation Act to £350, and a few witnesses have suggested that the income limit for non-manual workers should be similarly raised for National Insurance (Loyal Order of Ancient Shepherds, App. XLIV, 16; Q. 14,076-14,085; National Association of Trade Union Approved Societies, App. XCII, 55-59; Q. 21,855-21,856). But in regard to this point there has always (except for a short period pending the amendment of the Workmen's Compensation Act) been a difference between the two systems, the original limits having been respectively £160 and £250. We doubt whether such an extension would be welcomed by those primarily affected, and in any case we are of the opinion that any proposal to bring National Health Insurance into line in this respect with Workmen's Compensation would meet with strong opposition both from employers and from the Medical Profession. In the circumstances, the position should, we think, remain unaltered.

461. It was suggested to us by the British Medical Association that persons such as bank clerks, insurance officials, and others who normally pass beyond the income limit of insurability at a comparatively early age, should be excepted altogether from Health Insurance (App. XLVII, 15; Q. 14,877-14,890; 14,914-14,926). No claim was, however, made to us by, or in the name of, these particular classes of insured persons for their exception from the Scheme. On the contrary, we had some evidence that the protection provided by the Health Insurance system is becoming increasingly valued by persons of this class, and in particular that they desire to participate in the valuable additional

benefits in the form of treatment which are being provided out of the substantial surpluses accruing to the particular Societies catering for them. We return to this subject at a later stage in this Chapter (para. 589). We feel, moreover, that the demarcation of new classes for the purpose of adding to the list of employments to be excepted from insurance would give rise to very difficult administrative problems and, in practice, would be bound to lead to many hard cases. In this connexion we would refer to the evidence of Sir Walter Kinnear, Q. 23,397 and 23,403. We do not, therefore, recommend any alteration of the present income limits for compulsory insurance.

462. Another proposal for the exclusion from Health Insurance of a class of employed person who at present fall within the compulsory provisions of the Act was made to us by the Stepney Borough Council (App. LXXXVIII). The persons in question are men who are given casual work by the Council, e.g., on the cleansing of streets under schemes for the relief of unemployment. The main argument put forward by the Council in support of their proposal was that the whole period covered by employment of this nature in the case of any one man in any year was so short that he could derive little or no advantage by the payment of Health Insurance contributions in respect of the employment. On the other hand, however, even a short period of employment occurring in a prolonged spell of unemployment may be of value to an insured person, by reducing his arrears and thereby assisting him to avoid reduction in his benefits. Moreover, as was brought out in the examination of the witness who appeared before us on behalf of the Council, no case could be made out for differential treatment of this particular type of casual employment (*Barnby* Q. 21,325 and 21,330), while a general exception of all casual employment would give rise to serious difficulties involving great danger to the whole system of collection of contributions. We do not, therefore, see our way to make a recommendation in the direction desired.

463. A further suggestion for an extension of the classes of persons who are excepted from compulsory insurance was made to us by the Welsh Area of the National Union of Clerks and Administrative Workers (App. CXXXI, 7). The Union submitted that clerks and salaried officials who, as a condition of their employment, contribute to a fund which provides sickness and disablement benefits of at least equal value to those given by the Act, should be excepted. We cannot, however, see our way to recommend the adoption of this proposal. We would point out that there is not, in the case of employment of the nature referred to by the witnesses, the same security of tenure as in the case of employment under the Crown or by public authorities or statutory companies, nor are the conditions of employment of the permanent nature which characterises the various classes of employment which are already excepted.

464. We have received from the Ministry of Health one small suggestion for the extension of the classes of persons to be subject to compulsory insurance. It was pointed out to us (*Kinnear*, Q. 23,398, 23,400-23,402) that the ordinary test of contract of service is not fulfilled in the case of certain classes of persons who, although undoubtedly members of the wage-earning classes, cannot be said to be employed under the ordinary relationship of master and servant, e.g., tree fellers, hay cutters, stone breakers, market porters, and the like. Doubtful cases of this character are, we are informed, constantly arising for investigation by the Department, and the question of the existence of a contract of service often turns on fine distinctions in the facts, or in the way in which the facts are presented. Generally speaking, there is a desire for Health Insurance (but not so much for Unemployment Insurance) amongst these persons, and not uncommonly they stamp their own cards, sometimes as voluntary contributors, but more often, and in this case irregularly, as employed contributors. The employers, however, usually seek to avoid the payment of contributions whether exigible or not. It has been suggested to us that cases of this type should be included among the classes liable to insurance.

465. We are also reminded that the advent of the Widows', Orphans' and Old Age Contributory Pensions Act is bound to accentuate the difficulties referred to, and we are informed that during the passage of the Contributory Pensions Bill through Parliament there were several demands for the inclusion of workers of this class.

466. We are impressed by the evidence which we have received in regard to this matter, and we recommend that Part I of the First Schedule to the Act should be extended by the addition of a paragraph to the following effect:

> Employment under a contract for the performance of manual labour for the purpose of any trade or business, except in so far as such employment may be excluded by a Special Order. The person in or for the purpose of whose business the manual labour is performed shall be deemed for the purposes of this Act to be the employer of the person by whom such manual labour is performed.

467. The Special Order would provide for the exclusion of persons not ordinarily themselves engaged in the performance of manual labour under the contract and also possibly for any particular employments where the conditions do not approximate to a contract of service.

468. The class of persons we have in mind usually work fairly regularly for the same employers, but even where they work for several employers the collection of contributions should not be attended by any more difficulties than arise at present in the case of dockers and other casual labourers and outworkers.

Voluntary Contributors.

469. In considering the classes of persons to be insured under the Scheme, the general principle to be aimed at should, in our view, be to include as far as possible all those persons who cannot reasonably be expected by their own individual efforts to make provision similar to that which may be obtained under the Act. This principle is perhaps of easy application in the case of persons engaged by an employer, but there are, of course, large numbers of persons who are not so employed but whose need for the benefits provided by the Act is equally great. We have considered whether it is possible and desirable to make provision for the voluntary insurance of this class, which includes the small shopkeeper, the hawker, the crofter, and the like. We questioned Sir Walter Kinnear on this subject and may quote from his reply : " I may say with regard to the question of voluntary insurance of the small shopkeeper, and persons of that class, there is, of course, no employer in respect of such persons, so that there is no machinery by which we could properly get in the contributions. The Commission are aware that the 1911 Act allowed such persons to be insured as voluntary contributors at a rate of contribution graded according to their ages. The Ryan Committee in 1916 recommended that admission to this class should be abolished on the ground that only some 28,000 persons had availed themselves of the right of voluntary insurance and this number did not justify the troublesome administrative machinery that was required. This was done by the 1918 Act. Under the Contributory Pensions Act passed during this year a very wide door has been opened for a limited time to entry into voluntary insurance of persons who have at some time since July, 1912, had 104 weeks' insurance or excepted employment. So that, of course, the matter to a large extent has rectified itself. This will meet the case of the great majority of persons not now insured who may reasonably be allowed into voluntary insurance. It would not be practicable without a grading of contributions to give a continuing right to uninsured persons to come in as voluntary contributors, and we rather suggest that no extension of the existing provisions in this respect is called for, especially in view of the Pensions Act of this year." (Q. 23,398.)

470. At no time since the inception of the Act has the number of voluntary contributors been considerable, and we are informed that at the present time the number in England is only about 30,000. These are in the main persons who, having been employed contributors, desire to continue in insurance after ceasing insurable work. Voluntary contributors pay the whole weekly contributions themselves and receive the ordinary and additional benefits of their Society, subject to the limitation that a voluntary contributor whose total income from all sources exceeds £250

a year is not entitled to medical benefit, and in such cases the contribution is reduced by 2*d*.

471. We have received no evidence of any considerable demand for the extension of the existing facilities for voluntary insurance. Some societies have pointed out the limited number of the class and have commented on the fact that a large proportion of voluntary contributors do not continue the payment of their insurance contributions for more than a few years. The National Amalgamated Approved Society, for instance, informed us (Q. 10,581-10,585) that of a total membership of approximately $2\frac{1}{4}$ millions they had only 2,023 voluntary contributors, and that the tendency was for such contributors soon to drop out of insurance. Similar evidence was given by the Ancient Order of Foresters (Q. 4392-4395) and the Independent Order of Oddfellows, Manchester Unity (Q. 5815-5816; 6082-6084). The Act expressly provides that no married woman may be insured as a voluntary contributor. This restriction was no doubt included in the Act because of the extreme difficulty of supervising married women in receipt of Sickness or Disablement Benefit, and in particular, of seeing that the insured person does not, during sickness, continue to carry on to a greater or less extent her normal household duties. The National Union of Societies for Equal Citizenship have urged that this restriction should be withdrawn, and that married women should be allowed to be insured as voluntary contributors on the same terms as any other persons. (App. XCIX, 8; Q. 22,986-22,990; 23,007-23,009 and 23,013-23,018.)

472. In view of the serious difficulty just indicated we cannot recommend the adoption of this proposal. It must, however, be borne in mind that as regards maternity benefit, the married woman, who is not herself insured, will ordinarily be entitled to the benefit by virtue of her husband's insurance; and where the husband is not employed, special provision has now been made under the Widows', Orphans' and Old Age Contributory Pensions Act entitling the husband to become insured as a voluntary contributor if his wife was herself an insured person before marriage. If the uninsured wife of an insured man were permitted herself to become a voluntary contributor, the effect would be to evoke a double contribution for her existing rights to a widow's pension and a pension at 65, since contributions have to be paid under both Schemes by a single stamp.

473. The special conditions as to the reduction of contributions and the cessation of title to medical benefit in the case of voluntary contributors whose income exceeds £250 a year, and the provisions relating to the penalties for arrears in the case of such contributors, do not appear to have given rise to undue administrative difficulties, and although one Society (Rational Association Friendly Society, App. IX, 25; Q 6565

and 6603-6609) suggested that the title to medical benefit should be made general, the Joint Committee of Approved Societies, which speaks in the name of a considerable number of Societies, expressed their approval of the present provision in this respect (App. XIV, 2).

474. On the whole, we think that it is desirable to retain the class of voluntary contributor so as to provide effectively for those employed contributors who, on ceasing to be insurable, desire to continue their State Insurance. Not infrequently those who pass out of insurance, particularly if they do so in the earlier years of life, consider that they ought to be entitled to something in the nature of a surrender value on the ground that they have been compulsorily insured during a period when they might normally be expected to enjoy good health, and when, as may have happened, they have made little or no claim on the funds. The grant of a surrender value is not, however, entirely appropriate to a system of insurance against contingencies, as distinct from life assurance, where the event assured against is certain; and such a concession would, we consider, be very undesirable in a scheme of Health Insurance. But within the Scheme as it stands, it is possible to meet such hardship as would otherwise be entailed in passing out of insurance if provision is made whereby those affected who so desire, may continue as voluntary contributors. On the other hand, we do not think that there is any ground for recommending an extension of the class.

475. Having regard to the attitude of the medical profession to extension of contract practice, we think that on the whole it would be well to retain the existing arrangements relating to the £250 limit for medical benefit in the case of voluntary contributors.

SECTION B.— PAYMENT OF CONTRIBUTIONS

476. We were informed that the arrangements for securing the due payment of contributions under the Act are on the whole quite satisfactory. We may quote the following question which was addressed to Sir Walter Kinnear, and his reply :— "Do you think that there is any considerable non-compliance with the statutory requirements as to the payment of contributions?"—"Our calculations lead us to think that on the whole we collect about 99 per cent. of the contributions which are due We recognise that there is a certain degree of non-compliance amongst casually employed persons, and to a more limited extent amongst domestic servants." (Q. 213.)

477. On the other hand, we were informed that the Ministry considered that their powers for enforcing the payment of contributions could, with advantage, be strengthened. To indicate

the directions in which additional powers are thought to be needed, we cannot do better than quote two questions addressed to Sir Walter Kinnear, and his replies :—" Are you satisfied with the present powers of the Ministry for enforcing the provisions of the Act as to the payment of contributions, or do you think that they need strengthening in any respect? "—" There are one or two comparatively minor points upon which we think it would be to the advantage of insured persons and to the administration of the Act if we had some further powers. The time limit for taking criminal proceedings we suggest should be twelve months in the case of all offences specified under Section 96 of the Act. Section 97 allows a time limit of one year in the case of failure to pay contributions and in the case of trafficking in cards and used stamps, but proceedings for all other offences against the Act and Regulations are governed by the time limit of six months under the Summary Jurisdiction Acts, subject to the power of the Minister to extend the time by a certificate under Section 97 (1) (*b*). Many of these other offences are, however, closely linked up with the non-payment of contributions; for example, it often happens that prosecution for non-stamping is impracticable because the employer is believed to hold the relative card and prosecution for detention of the card is already barred by the six months' limit. In fact, we do not know of the offence until the six months' limit has expired. Other instances are the offences of fixing used stamps to a card, obstructing an inspector, failing to produce cards to an inspector, and making illegal deductions from wages. We are greatly hampered by the present time limit in the Act, and suggest that it should be made twelve months. There are one or two other smaller points. We suggest the period for which unpaid contributions can be recovered preferentially in bankruptcy or liquidation should be extended from four to twelve months. When the provision of four months was originally put into the Act we had a quarterly card, but now that we have a half-yearly card we think the period of twelve months would enable us to recover from the assets of a bankrupt unpaid contributions, and so help to keep the insured persons in benefit. There is another small point. We have had some cases recently of small limited companies which we have not been able to prosecute because of their being run by simply two or three directors, and we cannot prosecute for illegal deductions or for non-payment of contributions directors of companies. We think that, following the precedent of legislation set up in the Coal Mines Emergency Act, 1920, we should have power in the case of these small companies to conduct a prosecution against the directors where they were actively running the concern themselves, unless they could show that they could not reasonably be expected to have any knowledge of the non-compliance in question." (Q. 23,442.) " You think there is precedent for dealing in that way with

that particular kind of case? ''—'' It has been dealt with under the Coal Mines Emergency Act on the question of the illegal deduction of wages. There is one point we did get right under the Unemployment Insurance Scheme, and which we want badly in the Health Insurance Scheme. When our inspectors go round and visit employers to see if the cards are properly stamped, fraudulent statements are very often made. An employer may say, ' I have two men,' when in fact he may have six. Consequently, persons lose their benefit rights because the employer has been defrauding under the Act, and we suggest that the making of fraudulent statements in order to avoid payments under the Act should be made an offence under the Act in a similar manner as it is under the Unemployment Insurance Scheme.'' (Q. 23,443.)

478. We are prepared to accept the opinion of the Ministry as to the extent to which their present powers have proved in practice to be not altogether adequate, and we think that they should be given all reasonable powers which they think necessary for enforcing the provisions of the Act. We, therefore, recommend :—

(1) That the time limit for instituting proceedings for any of the offences specified in Section 96 (2) and (3) of the Act should be extended to twelve months.

(2) That Section 96 (1) of the Act should be amplified so as to render liable to prosecution any person who makes a fraudulent statement with a view to avoiding compliance with the Act.

(3) That the offences of trafficking in stamps should be made subject to the penalty of imprisonment as an alternative to a fine.

(4) That the preferential period for the recovery of unpaid contributions in the case of bankruptcy or companies in liquidation should be extended from four months to twelve months.

(5) That directors of companies who are actively engaged in the conduct of the company's business should be made personally liable for the non-payment of contributions due in respect of employees unless they can show that they could not reasonably be expected to have knowledge of the default.

479. A further suggestion was made to us (*National Association of Trade Union Approved Societies*, App. XCII, 72) that in order to avoid the hardship which falls upon insured persons through their employers failing to pay contributions at the proper time and subsequently becoming bankrupt before the contributions were paid, the contributions so lost should be made good out of insurance funds. We are, however, unable to recommend the adoption of this proposal. In the first place, we are not aware of

any insurance funds which are available for such a purpose, and even if funds were available, we doubt whether the course suggested would be desirable, as it might encourage laxity in the payment of contributions at the proper time. Moreover, it might prove embarrassing as a precedent if cited in support of a similar demand in cases not involving bankruptcy, e.g., where an employer had disappeared.

SECTION C.—ADMINISTRATION OF THE CASH BENEFITS.

480. We have received very little evidence in criticism of the provisions of the Act with regard to the administration of sickness and disablement benefits and the conditions to be complied with by insured persons in order to obtain those benefits. There are, however, a few points on which suggestions have been made for minor modifications, and these we will now proceed to examine.

Late Notice of Illness.

481. Our attention was directed to the provisions of the Act with regard to insured persons who do not give prompt notice of an illness for which they desire to claim benefit. Prior to 1918 title to sickness benefit was not made conditional upon the giving of notice of illness within any prescribed period after the commencement of incapacity, and it was found that many claims for benefit were received from members after their recovery, when it was no longer possible to supervise the claims. Provision was therefore included in Section 12(2) of the 1918 Act (now Section 13(4) of the 1924 Act) whereby an insured person claiming sickness or disablement benefit is required to furnish notice of incapacity to his society within three days of the commencement of his illness, and if he does not do so, benefit does not in normal circumstances commence until the day following the date of notice. The proviso to the subsection, however, exempts from the operation of this clause those persons who are able to satisfy the Society that they were " not reasonably able " to furnish notice within the prescribed time.

482. We are informed that the terms of the proviso to which we have referred have been found in the light of experience to be not altogether satisfactory (*Kinnear*, Q. 23,495). Some Societies place a strict interpretation upon the phrase " not reasonably able," and we understand that confirmation of the view taken by those Societies is afforded by the findings of a referee appointed by the Minister under Section 90 of the 1924 Act in a case recently referred to him on appeal, in which it was decided that the words of the proviso must be construed as implying physical inability. Many cases arise, however, where in strictness it may not be possible to contend that the person concerned is physically unable to furnish notice of illness, but yet he

cannot be said to be "reasonably able" to do so if all the circumstances of his illness are taken into consideration. It has accordingly been represented to us that the proviso should be amended so that members will not be penalised in cases of this type by reason of delay in furnishing notice of illness.

483. We are impressed by the considerations which have been submitted to us in this respect, and recommend that the proviso to sub-section (4) of Section 13 of the Act should be amended in the following sense: "Provided that, if the Society or Committee administering the benefit consider, or if in the case of a dispute it is decided in manner provided by this Act, that having regard to the circumstances of his incapacity, the insured person had reasonable excuse for his failure to give notice . . . &c."

Duration of Sickness Benefit and Linking-up Illnesses.

484. It is provided by Section 13 (5) of the Act that in calculating the maximum period of 26 weeks for which sickness benefit is payable, any illness which begins within twelve months of the termination of a previous illness is to be treated as a continuation of that illness. Further the linking-up provisions have regard to any illness in respect of which the insured person could have claimed benefit, irrespective of whether benefit was in fact claimed. This provision, we are informed, may operate harshly in the case of a person who is ill for a short period in each year during a number of consecutive years (*Kinnear*, Q. 345-349; Manchester Unity of Oddfellows, Q. 6079-6081), and we understand that certain Societies have habitually made detailed inquiries of employers with a view to determining whether a member claiming sickness benefit has had an odd day or two of incapacity during the preceding twelve months which would justify them in applying the provision in question (*Kinnear*, Q. 23,491).

485. A suggestion was made to us by the Ministry of Health as to an amendment of Section 13(5) of the Act, and we quote the following from the evidence of Sir Walter Kinnear: "This position operates harshly in the case of a person who is ill for a short period in each year, and the hardship is one which increases as the person grows older. It does not appear to be equitable that a week's sickness at some previous date should make the possible difference between 26 weeks of sickness benefit and 26 weeks of disablement benefit for a subsequent incapacity, and it seems desirable to avoid any inducement to an insured person to delay claiming benefit in order to secure a title to sickness instead of disablement benefit . . . . . It is suggested that Section 13(5) might be amended so as to provide that for linking-up purposes any period of 12 months during which the insured person has not received benefit in respect of more than six days of incapacity should be regarded as a year free from

incapacity. If the Commission could see their way to recommend something like that, I think it would be a great boon to persons, say, between 50 and 60 years of age who normally anticipate being laid up for a few days in each year." (Q. 23,481-23,482.)

486. We are convinced that the Section as at present worded is severe in operation, especially in the case of the person who suffers from no more than the average amount of sickness each year.

487. We therefore recommend that Section 13 (5) of the Act should be amended so as to provide that in determining whether an illness is to be treated as a continuation of a former illness, no account shall be taken of any short periods of illness amounting in the aggregate to not more than six days in the twelve months immediately preceding the commencement of the later illness. This recommendation probably involves no increase of cost in the aggregate since the claim in respect of the illness next following the year in which there have been no more than six days of benefit will be subject to a three days' waiting period—a condition which does not apply at present.

Inmates of Institutions.

488. It is provided in Section 17 of the Act that where an insured person having no dependants is during illness an inmate of a workhouse, hospital, asylum or similar institution supported out of public funds, or by a charity or voluntary subscriptions, no payment of sickness or disablement benefit is to be made to him while he is in the institution, but that the money may be applied in various ways, and that any balance not so applied is to be payable to him on leaving the institution, or to his legal representatives in the event of his death in the institution. We have been informed that the balances so payable have in many cases accumulated to very considerable sums. As an illustration, we may refer to the table submitted by the Hearts of Oak Benefit Society. (App. IV, 161.)

489. Several witnesses have suggested to us that some limit should be placed on the amount of accumulated money which should be payable to an insured person or to his legal representatives in such cases. The Hearts of Oak Benefit Society suggest that the maximum accumulation should be £50, and that any further balance should remain in the Society's Benefit Fund (App. IV, 158-173; Q. 3250-3258, 3337-3340, 3435-3437). The Manchester Unity of Oddfellows suggest that the maximum should be the equivalent of twelve months' benefit, approximately £29 (App. VII, 70-72; Q. 5902). The Group of Catholic Approved Societies do not go so far, but suggest that provision should be made for the disposal on the death of the insured person, of the

accrued benefit " which under normal circumstances goes to people who have never done anything for the sick person and who, by some means or other, get the nomination and get £30, £40, £50, or £60 " (Q. 8604-8605). The United Women's Insurance Society suggest that the benefit payable on death to any person other than a near relative should be limited either to one year's cash benefit or should be in the nature of a refund of funeral expenses, and the like (Q. 10,194, 10,222-10,231). The National Amalgamated Approved Society suggest that only 25 per cent. of the benefit accrued at death should be paid to the next-of-kin who defrayed the cost of burial, and that the balance should go to the Institution (Q. 10,587-10,593). That Society hold at the moment £42,000 of accrued benefit of this type.

490. The Grand United Order of Oddfellows suggest a reversion to the position as it existed prior to 1918, under which the accumulated benefit remained in the funds of the Societies. This Society also submits a table giving particulars of 15 cases in which benefits varying in amount from £51 to £177 had accrued due to members of the Society on the 31st December, 1924 (App. XCV, 14-20; Q. 22,458-22,477). Sir Walter Kinnear expressed the view that " there is much force in the contention of the witnesses as to the payment of large accumulated sums in respect of insured persons who have been in institutions. No inducement should be given to a Society to avoid applying the amount of benefit in the ways provided by the Section of the Act, that is, payment to the insured person's dependants, for payment of expenses for which he is liable otherwise than to the institution, or in some circumstances, payment to the institution; and we are inclined to think that if after reasonable payments have been made in these ways there remains a balance exceeding, say, £50 to be paid on the death of the member or on his discharge from the institution, the amount in excess of that £50 should be withheld and paid by the Society to the Central Fund. It should not be left in the funds of the Society." (Q. 23,749.)

491. We feel that there is a strong argument on general grounds against paying large sums to the insured person on exit from such institutions under these conditions, or to the legal representatives on death. It should be remembered that in the circumstances postulated the insured person will have been fully maintained in the institution and that, therefore, compared with the person who has been drawing benefit at his own home, he will be in an equally favourable position on leaving the institution quite apart from these accumulations. On the other hand, we think there is some argument for payment of such sum as will meet the funeral expenses and clear up the affairs of a deceased insured person who has no dependants : or in the case of a person who leaves the institution, will be sufficient to

tide over a period of transition. We think that the sum provided for this purpose should not exceed £50 and that the balance should be paid over at yearly or half-yearly intervals by the Society to the Central Fund. We do not think that there is any argument for allowing this balance to accrue to the Benefit Fund of the Society as has been suggested by certain witnesses.

492. Suggestions have been made by witnesses appearing before us on behalf of Poor Law Authorities that the Act should be so amended as to empower Approved Societies to pay to Boards of Guardians the Sickness Benefit of members who are inmates of Poor Law institutions and have no dependants. (Association of Parish Councils of Scotland, App. LXXX, Q. 20,535-20,636; Association of Poor Law Unions of England and Wales, App. XC, 29-42; Q. 21,703-21,714.) It is urged that in a considerable number of cases of this kind the insured person obtains his discharge from the institution after a considerable sum has accrued to his credit as benefit, that the accrued benefit is paid to him in a lump sum by his Society and that, having quickly dissipated the benefit, he finds his way back to the institution. We are informed that the specific provision which debars the payment to the Poor Law Authorities of any part of the benefit arising from the insurance of an inmate of a workhouse, Poor Law infirmary, asylum or other similar institution maintained out of public funds, was included in the 1918 Act following a recommendation of the Departmental Committee on Approved Society Finance and Administration.

493. We see no reason for departing from the principle that benefits derived from the compulsory contributions of employers and employed should not be applied towards the relief of local rates.

494. It has been suggested, however, that the cases to which we have referred would, to a large extent, be met if the discretionary power now entrusted to Societies enabling them to make payments of accrued benefit either in a lump sum or in instalments after the insured person's discharge from an institution were replaced by a compulsory provision that in the case of persons without dependants, any benefit accrued in respect of their insurance during a period when they have been inmates of the institution should in all cases be paid to them on their discharge in weekly instalments. (*Kinnear*, Q. 23,749.)

495. We agree that such a provision would undoubtedly go a long way towards meeting the particular criticism of the Poor Law Authorities to which reference is made above. We accordingly recommend that Section 17 (3) of the Act should be amended so as to provide that where an insured person without dependants has been an inmate of an institution, any balance of the accrued benefit payable to him on his discharge shall in all

cases be paid in instalments at a weekly rate equal to the rate of sickness benefit normally payable by the Society.

496. We also think that the attention of Societies should be directed to the provisions of Section 17 (2) (*b*) of the Act under which they are empowered to make payments towards defraying expenses of members during their stay in an institution, and that Societies should be encouraged to make fuller use of that power by meeting the cost of small additional comforts for their members in such circumstances.

Recovery of Benefit Overpaid.

497. We have considered the position as to the recovery from an insured person of any sum received by him from his Society as a payment in respect of benefit to which he was not entitled, and we examined Sir Walter Kinnear on the subject (*Kinnear*, Q. 23,825). We find that the Act makes no provision for recovery by the Society except in the following three types of cases :

(1) Benefit paid by way of advance pending the settlement of a claim for compensation (Section 16 (4)).

(2) Benefit paid by way of advance pending the settlement of a claim for a 100 per cent. disablement pension (Section 60 (2)).

(3) Payment of ordinary benefit to a married woman who was entitled to the special benefits of Class K only (*see* para. 515), but who had failed to notify her Society of her marriage (Section 56 (9)).

498. On the other hand, it is provided by Section 21 of the Act that every assignment of any of the benefits of the Act shall be void.

499. In cases of overpayment other than those mentioned above, the present position is, therefore, that the Society stands to the member in the ordinary position of creditor to debtor, and is not entitled to withhold from the member any benefit which may subsequently become due to him in order to recoup itself for the previous overpayment.

500. We are informed that there is ample evidence before the Department to show that notwithstanding the last-named provision, Societies in practice frequently recover overpayments by withholding benefit subsequently payable, and moreover, often do so without the member's consent. Recovery of overpayments by this means often involves hardship to the member, as he is called upon to repay a debt when he can least afford to do so. There is good reason to believe that Societies adopt this method of recovery because the alternative methods are either ineffective or (as in the case of legal process) involve a maximum trouble and embarrassment to all concerned.

501. We think that this problem is undoubtedly one of difficulty from the point of view of the administration of Societies, and we are convinced that there is a very good case for giving Societies a legal remedy which will, at the same time, protect an insured person from the hardship which would be involved in a complete stoppage of benefit. A time limit should, however, in our view, be imposed.

502. We therefore recommend that provision should be made whereby Societies will be empowered (in cases not falling within the three classes above mentioned) to recover, without prejudice to any existing right of recovery, overpayments of benefit by withholding weekly from sickness or disablement benefit due in respect of subsequent periods of incapacity occurring within 12 months of the date on which the overpayment was brought to the notice of the member, an amount not exceeding one-third of any sum payable in respect of sickness or disablement benefit.

Benefit for Tuberculous Insured Persons in Part-Time Employment.

503. To one special point brought forward in the evidence relating to the question of tuberculosis we would refer in connexion with the administration of sickness benefit. It has been urged upon us by the Cambridgeshire Tuberculosis After-Care Association (App. LXXXIII, 2-14), the London County Council (App. LXXXIV, 34-35), and the Joint Tuberculosis Council (App. XCIII, 12), that a reduced sickness benefit should be allowed during such part-time employment of tuberculous persons as they take up under medical advice. It appears that such part-time employment is often a very beneficial element in the measures for curing or alleviating this disease, provided that the work is carried on under proper conditions and subject to medical supervision. We are not unsympathetic to this proposal on general grounds, and we are glad to know that in fact the Ministry of Health approves some such relaxation of the necessarily strict rules governing the payment of sickness benefit in the case of persons in Tuberculosis Colonies such as Papworth. But we see considerable difficulties in any attempt to extend the arrangement to persons in ordinary employment. It would be difficult to secure the proper medical supervision and the appropriate conditions of work in business concerns which necessarily must organise their arrangements on a commercial basis. Employers could not be expected to conform to a number of restrictions directed primarily towards the care of a small and specially affected proportion of their workers. We may add that, though provision for the payment of a disablement allowance to members not totally incapable of work is included among the additional benefits of the Act, this benefit has been found administratively impracticable and has never been adopted

(*Kinnear*, Q. 23,689-690, 23,781). We may also point out that there are other illnesses, such as neurasthenia, in respect of which an almost equally strong case could be made for a similar concession. Any modification of the kind suggested would add seriously to the difficulties attending medical certification and the determination of claims for benefit. We accordingly do not think that this suggestion for the special case of the tuberculous persons can be recommended.

Medical Certification.

504. It is indispensable to the proper administration of sickness and disablement benefits that the incapacity of the insured person who is claiming benefit should be medically certified at frequent intervals, and the provision of certificates is accordingly one of the duties undertaken by the insurance practitioners under their contracts with the Insurance Committees. Under the present arrangements a certificate is supplied at the outset of incapacity, a second, if necessary, after not more than seven days, and thereafter once weekly; but in cases of prolonged incapacity, where the doctor does not regard it as necessary to see the patient more frequently than once in four weeks, it is open to him, with the concurrence of the Society, to give certificates separated by this interval.

505. It has been submitted to us in the evidence of the British Medical Association that these periods should be extended at the option of the practitioner to 14 days in the case of sickness benefit and 42 days (or in rural areas three months) in the case of disablement benefit (App. XLVII, 53). In examination, it appeared that proposals to this effect had been made by the profession to the Approved Societies but had not been accepted. We have not ourselves thought it necessary to recall witnesses from the Societies to give evidence upon the point, in view of the facts which were brought out in the investigations of the Actuarial Committee. These facts, had they been available to the profession when its proposals were being formulated must, we think, have raised in the minds of the medical witnesses the same doubts as to the wisdom of this proposal as they have in ours. The First Report of the Actuarial Committee shows, as we have elsewhere explained, a constant and serious rise in the sickness claims of women and in the disablement claims of both sexes; and it is pointed out, moreover, in the Appendix to that Report (para. 11), that of those who receive disablement benefit in the course of a year, a large proportion rising, at the ages under 40, to 40-50 per cent., "go off the funds" during the year, thus showing that those in receipt of this benefit at any time are, as a class, very far from being a body of permanently sick persons. In these circumstances the need seems to be for more, rather than less, supervision, and it is impossible for us

to endorse a proposal which would be resisted by the Societies, and probably with reason, as being likely to increase whatever difficulties are now encountered in the oversight of claims. A system of fortnightly certificates in connection with sickness claims which, as the figures given by the Actuarial Committee show, do not last on the average for as long as five weeks in the case of men or more than six weeks in the case of women, would give the insured person such a wide discretion, unfettered by medical control, as to the day of "declaring off," as to create the risk of the period of claim being seriously prolonged in a certain proportion of cases with corresponding effect on the cost of the benefit. We cannot doubt that this would be the result in the case of disablement benefit, and in these circumstances we feel that it is impossible for us to endorse the proposal made to us by the British Medical Association.

Re-insurance of Maternity Benefit.

506. Section 25 of the Act enables the Minister to make provision for the re-insurance with him of the liabilities of all Societies in respect of Maternity Benefit. Up to the present, this provision has not been put into operation. Suggestions were made to us by witnesses from various Approved Societies for giving effect to the Section, and in support of the case for re-insurance of the risk it was stated that the maternity benefit experience is the highest in the case of those Societies with the least favourable sickness experience. Thus, the National Association of Trade Union Approved Societies state that "the incidence of risk in respect of maternity benefit varies considerably as between Society and Society. There is also considerable variation in the cost to Societies of Section 14 (4) and (5) of the Act, which provides for a second maternity benefit being payable in certain cases from the woman's insurance." The Association submit "that the Minister should take the powers conferred upon him by Section 25 of the Act for the reinsurance of maternity benefit, thus spreading the risks equitably over the whole insured population." (App. XCII, 125-126; Q. 22,057.) Similar suggestions were made to us by the representatives of other Societies.

507. We also examined a representative of the Ministry of Health on the subject. (*Kinnear*, Q. 23,480.) We are informed that this question was examined in 1912 by the Actuarial Advisory Committee set up when the Act came into force, who advised that re-insurance was not to be recommended. The Committee indicated that deviations from normal experience would be either—

(1) temporary fluctuations due to limitations of number of members of particular Societies; or

(2) permanent deviations due to the character and circumstances of sections of the population or to geographical differences.

As to (1) the Committee thought that there was no serious risk of a Society having excessive claims for several years in succession; and as to (2), the problem did not appear to them, after examination of the statistical data, to be of such magnitude as to call for special treatment.

508. In accordance, however, with their instructions they prepared a scheme for re-insurance. This scheme brought out the complications inherent in the proposition and demonstrated the heavy labour which would be involved in applying any sound arrangement of the kind.

509. On the first (1918) valuation the Government Actuary reported a saving in maternity benefit payments on men's insurance of 20 per cent. of the expected payments, and on women's insurance of 36 per cent. One factor was the reduced birth rate during the war; but an examination of the experience since 1918 suggests that the maternity payments will, in general, continue to be within the financial provision for the benefit, and that any excess in particular Societies is not of sufficient importance to justify the introduction of a complicated system of re-insurance.

510. We are of the opinion that reinsurance in the strict sense, i.e., by distributing the charge with reference to the actuarial value of the risk undertaken by each individual Society in respect of the benefit is not practicable. We are advised, moreover, that in the calculation of the contribution and reserve values as well as in the valuations, account is taken of the varied incidence of the cost of maternity benefit with regard to age, sex, and in the case of women, marital condition, and that a mere pooling of the cost at a uniform rate per head of the membership would be inconsistent with these conditions, while it would certainly be inequitable.

511. We, therefore, recommend that no steps should be taken to put into operation the provisions of Section 25 of the Act, and that the section should be repealed.

SECTION D.—SPECIAL CLASSES OF INSURED PERSONS.

Married Women.

512. The question of the provision to be made with regard to the insurance of women who give up insurable employment at or about the time of their marriage has from the first been a matter of great difficulty. Under Section 44 of the Act of 1911 insured women who married had, in the first place, to satisfy their Approved Societies as to whether they had definitely given up employment or not. No precise test of cessation of employment was laid down in the Act and in practice it followed that Societies were to a large extent compelled to depend upon the woman's

statement as to whether, though absent from work at the time, it was her intention to resume employment in the future. The woman who satisfied her Society that she had not definitely given up employment was allowed to retain the title to all benefits under her existing insurance, while the woman who was treated as having given up employment was allowed to exercise an option between taking up a new voluntary insurance for reduced benefits at a low rate of contribution, or drawing in times of illness upon the very limited amount of her own transfer value. These provisions were found thoroughly unsatisfactory in practice, mainly on the ground that the action to be taken by the Society depended upon a statement of the woman's intention, which was in the nature of things impossible of verification, and also by reason of a decision of the Court of Appeal (Davidson *v.* New Tabernacle (Old Street Congregational) Approved Society [1916], 2 K.B. 80), which appeared to place upon the section an interpretation which would have proved most embarrassing in administration.

513. The position was thoroughly examined in 1916 by the Departmental Committee on Approved Society Finance and Administration, and the Report of that Committee contained recommendations designed to clarify the position and to overcome the administrative difficulties to which the provisions of the Act of 1911 had given rise. These recommendations were embodied in the Bill of 1918, but in the course of the passage of the Bill through Parliament they became the subject of some criticism which was mainly directed against the proposal that one of the options to be allowed to insured women who cease work on marriage should be the right to receive a lump sum payment by way of a marriage benefit or bonus. It was urged that this was not a proper use to which to put funds collected for insurance purposes under a system of compulsory contributions. As a result of this criticism the Bill was amended and the Scheme which is now in force and is contained in Section 56 of the Act of 1924, was substituted.

514. The present provisions of the Act relating to married women differentiate between those insured women who continue in employment after marriage and those who are regarded as having then ceased to be employed, and a definite test, easy of application, is provided to determine whether a woman is to be treated as having ceased employment or not. A woman who at the time of her marriage, or within one year thereafter, has had a period of eight consecutive weeks' absence from work otherwise than by reason of illness is to be treated as having ceased to be employed, and from the end of those eight weeks a special limited form of insurance (Class K) is provided for her. On the other hand, a woman who has not had eight weeks of such absence from work continues in insurance as an employed con-

tributor. If a woman remains at work for a full year from the date of her marriage without eight consecutive weeks' absence, she becomes permanently exempt from transfer to the special class of insurance and on subsequently ceasing work at any time she is subject to the ordinary provisions of the Act and is entitled to a free year's insurance from the date of ceasing employment as in the case of other insured persons. It will be observed that under this procedure the woman's transfer to the special class of insurance depends on easily ascertainable facts, and that the consideration of " intention," so unsatisfactory in practice, is eliminated.

515. The special benefits provided under the Act for women who cease work on or about the time of marriage are as follows :—

(1) Sickness or disablement benefit at the rate of 7*s.* 6*d.* a week for a maximum period of six weeks during a period of one year from the " date of unemployment " (i.e., the end of the eight consecutive weeks of unemployment).

(2) Medical benefit for a year from the end of the half-year in which the " date of unemployment " falls.

(3) A single maternity benefit of 40*s.* on the first confinement after the " date of unemployment," provided that such confinement occurs within two years after the date of marriage.

(4) Any additional benefits provided under the scheme made by the Society of which the woman is a member, so far as these are applicable to her case.

516. We have received no criticism of the nature of the benefits under this special scheme of insurance, but we have had criticism on other grounds from several sources. For instance, the National Conference of Industrial Assurance Approved Societies (App. VI, 15-16; Q. 4999-5059) and the Prudential Approved Societies (App XXI, 6; Q. 9677-9683) stated that the present provisions were complicated and difficult to administer, and suggested that every insured woman who marries should be allowed to exercise an option between the two following alternatives :—

(1) To receive a cash payment, in which case her insurance would terminate whether or not she remained in employment; or

(2) To be treated in the same way as any other person who ceases employment, i.e., to be given a continued title to all cash benefits for 12 months after ceasing work and to medical benefit for a further period.

517. Other witnesses, e.g., the Manchester Unity of Oddfellows (App. VII, 63; Q. 5843-5845) and the Rational Association Friendly Society (App IX, 24; Q. 6513-6515, 6527-6532,

6555-6558) also criticised the scheme on the ground of its complexity and suggested that the normal provisions of the Act for a free year of insurance should be applied. The latter of these Societies also submitted interesting tables (App. IX) showing the percentage of women who fell under Class K on marriage and the relative cost of the two schemes. The National Association of Trade Union Approved Societies (App. XCII, 123; Q. 22,057) also suggested the application of the "free year of insurance" but expressed the view that the woman's title to maternity benefit should continue for two years after marriage. Again, certain witnesses, including the Ancient Order of Foresters (App. V, 54-56; Q. 4268, 4278-4284), the Joint Committee of Approved Societies (App. XIV, 10; Q. 8237-8241) and the Scottish Co-operative Friendly Society (App. LXXVIII, 4; Q. 20,174-20,213) suggested that a marriage bonus should be given to women on marriage and that the title to all benefits should then cease. The present arrangements were also criticised on the ground that they provide little incentive to insured women to send prompt notification to their Societies of the fact of their marriage, with the result that benefits are often paid in the first instance at incorrect rates, necessitating subsequent adjustments (*Kinnear*, Q. 229-232; *Manchester Unity of Oddfellows*, Q. 5843; *Order of the Sons of Temperance*, Q. 21,433).

518. Finally, it has been represented to us by several witnesses, that the difficulties in administering the present provisions are rendered greater at the present time by reason of the necessity for applying to each case the provisions of the Prolongation of Insurance Act (e.g., *Hearts of Oak Benefit Society* (App. IV, 124-126; Q. 3134-3136), *Ancient Order of Foresters* (Q. 4349-4351), *Independent Order of Rechabites* (App. VIII, 9-11), *National Conference of Industrial Assurance Approved Societies* (App. VI, 16)). Under this Act the definite test of eight consecutive weeks' absence from work for determining whether a woman is to be treated as having ceased employment no longer applies, and in every case where there has been this period of absence from work, a Society before transferring a woman to the special class of insurance has to ascertain whether during the period she has been genuinely unemployed and available for work, or not. In the former case she is not transferred to the special class but is allowed to remain in insurance as an ordinary employed contributor. This, we are told, removes the main administrative advantage of the provisions of the Act of 1918 and reintroduces to some extent the necessity for ascertaining intention, which was the main objection to the relative provisions of the 1911 Act.

519. The objections, from an administrative point of view, to the present provisions relating to married women, so far as these objections are based on their alleged complexity, appear to be

more particularly entertained by the smaller Societies. In the larger Societies the necessity for applying those provisions arises almost daily in the ordinary routine of business, and the officials of those Societies who deal with such cases have become so familiar with the work that it does not generally present any serious difficulties to them and, as a result, mistakes are comparatively rare. In the smaller Societies, however, where the transfer to Class K is not a matter of every-day occurrence, it is probable that the administration of the present provisions does give rise to difficulty and that mistakes may from time to time occur.

520. We now proceed to examine the two main proposals which have been placed before us for varying the present provisions of the Act with regard to the insured woman who marries. These are a marriage bonus and a free year's insurance.

521. The chief arguments advanced in support of the proposal to provide a bonus to all insured women who marry are, first, that it would be a popular benefit in a large proportion of cases and might be expected to lead to prompt notification of marriage, a consequence eminently desirable in the interests of proper administration; and, secondly, that it would be very convenient from the point of view of simplicity of administration if the woman's previous insurance could be completely brought to an end by such a lump sum payment. We do not consider that the arguments in support of this proposal are sufficiently strong to justify a reversal of the decision of Parliament on the subject to which we have referred above, and we are of opinion that such an application of Health Insurance funds would be contrary to the general intention of the Act and would be out of place in a national scheme of Health Insurance. The proposal would, moreover, involve fresh waiting periods for benefits in the case of women who remain continuously in employment after marriage. We do not, therefore, recommend the adoption of this proposal.

522. The proposal that insured women who cease work at or about the time of marriage should be treated in exactly the same way as other insured persons who cease insurable employment is attractive from the point of view of simplicity of administration. It would free Societies from the risk of making incorrect payments through the member's failure to notify her marriage; and the ordinary procedure, with which all Societies are familiar and which can be followed automatically on the basis of the surrender or non-surrender of stamped cards, would be followed. For the reasons which we set out below, however, we do not consider that this plan is feasible and we are unable to recommend its adoption. Marriage marks not only a change in the economic status of the woman who marries, but also a change in her liability to the risks against which she is insured; and for

these reasons we are satisfied that some special provision is essential to meet the peculiar circumstances of insured women on marriage. On the grounds indicated it would, in our opinion, be impossible to extend to insured women who cease employment at the time of marriage the ordinary provisions as to the granting of a free year's insurance. It must be borne in mind that the so-called "free year" is not a fixed period of twelve months, but is an elastic period capable of indefinite extension. In the first place, if any period of illness occurs during the first twelve months of free insurance, the period of insurance is extended by a period equal in length to that of the illness, and in the event of prolonged or permanent incapacity occurring the ordinary insured person would continue entitled to benefit long after the termination of the first twelve months of free insurance. It would be an altogether impossible financial proposition to allow of such indefinite extension in the case of women who had left work on marriage, and were consequently not suffering loss of wages during the period of incapacity. A point of much importance from the point of view of the insured woman herself is, however, that the great majority of insured women leave industrial employment on their marriage, and the limitation of their subsequent title to benefit to a period of twelve months would exclude a large proportion of them from drawing maternity benefit on the occasion of their first confinement. We have had ample evidence that this benefit—which the present system is designed to secure—is greatly valued, and we are not disposed to recommend an alteration under which it would be jeopardized.

523. But, while we cannot recommend that the ordinary provisions of the Act should be applied without any modification to insured women who cease employment on marriage, we recognise the advantages of making the special provision which is essential in such cases conform to the normal provision except where a departure from the normal is required to meet the circumstances of the case. In particular, we do not think that it is advisable to retain a special reduced rate of Sickness Benefit, and we recommend that this benefit should be paid at the woman's ordinary rates. We are advised by the Actuarial Committee that it would be possible, within the available financial provision, to increase the benefit to this extent provided that the present maximum period of six weeks for Sickness Benefit is retained. We are satisfied that insured women who continue in employment after marriage should, as at present, remain in insurance as ordinary employed contributors. We also consider that the present test of cessation of employment, viz.: eight consecutive weeks of voluntary abstention from work under an employer, is satisfactory and should be retained. Any weeks during which the woman is away from work by reason of sickness should not be counted towards these eight weeks, and a similar concession should be made in respect of weeks of genuine in-

ability to obtain work subject to arrangements being made for the certification of unemployment by Employment Exchanges or its establishment otherwise in accordance with our recommendation in paragraph 655.

524. At the end of eight consecutive weeks of voluntary abstention from employment a woman should be transferred to a special class of insurance on the lines of the present arrangement and would become entitled to special benefits for a limited period. The special benefits which we recommend are :—

(1) Sickness Benefit subject to the usual three days' waiting period at the ordinary rate for a maximum period of six weeks during a fixed period of twelve months from the date of the transfer to the special class; this benefit should not be liable to be linked up with previous sickness, thus entailing a liability of reduction to the rate of disablement benefit.

(2) A single Maternity Benefit at the ordinary rate on the first confinement within two years after the date of marriage.

(3) Medical Benefit up to the 30th June or 31st December next following the anniversary of the date of transfer to the special class.

(4) Any additional benefits provided under the Scheme of the Society of which the woman is a member,

525. We also recommend that the ordinary penalties for arrears should be applied, with the exception that Maternity Benefit should in all cases be paid in full, irrespective of arrears. We recommend the retention of the present provision that a woman who returns to employment after having been transferred to the special class should be treated as a new entrant, and that pending her qualification for benefits in respect of her new insurance she should continue to be entitled to the benefits of the special class so far as her title had not already been exhausted.

Exempt Persons.

526. The statutory grounds on which a person employed within the meaning of the Act is entitled to claim exemption are—

(1) the receipt of a pension or private income of at least £26 a year;

(2) dependence for his livelihood on another person;

(3) dependence on another occupation which is not insurable;

(4) the intermittent nature of his employment.

527. The number of exempt persons is small in relation to the insured population, amounting in England to approximately 33,600, of whom 24,700 have claimed on the ground of pension

or private income; 3,900 on the ground of dependence on another person; 300 on account of dependence on another occupation; 4,600 under the temporary provisions of the Act of 1919, and less than 100 on the score of intermittent employment. It will be seen, therefore, that the bulk of the cases are those in which the claim is made on the ground of pension or private income of £26 a year or more.

528. Where a certificate of exemption is granted, it in no way operates to relieve the employer of his liability to pay what would have been his appropriate share of the contribution had the employed person not received exemption. Contributions are thus paid in respect of exempt persons, but by the employer only. In respect of these contributions the exempt person becomes entitled to receive Medical Benefit, and we understand that the majority take advantage of this benefit.

529. Three points arise for consideration—

(1) Whether the class should be abolished altogether, so that these persons would fall into the same category as ordinary insured persons.

(2) Whether the requirement to pay the employer's share of the contribution should be abolished, with the effect of placing exempt persons in the same position as those of the excepted classes.

(3) Whether, continuing the present system, the arrangements under the 1911 Act, under which no benefit at all was given to these persons, should be reverted to, and the contributions collected in respect of them otherwise applied.

530. The Hearts of Oak Benefit Society suggest the retention of the class and the withdrawal of Medical Benefit, the contributions payable in respect of exempt persons being applied towards the cost of Medical Benefit for the dependants of insured persons (App. IV, 20-24; Q. 2571-2575). The Manchester Unity of Oddfellows suggest the amendment of Section 2 (1) (*a*) of the Act, which gives a title to exemption to persons in receipt of a pension or private income of £26 or more, but express the opinion that if the class is retained there would be some justification for considering the withdrawal of the right to medical benefit. (App. VII, 73-74; Q. 5903-5905). The National Association of Trade Union Approved Societies suggest the repeal of Section 2 (1) (*a*) of the Act (App. XCII, 75; Q. 21,857 and 21,914). The Scottish Board of Health think that there is no justification for this special class, that exempt persons have little claim for consideration, but that Medical Benefit is valued by them (*Leishman*, Q. 1554-1563). The view of the Ministry of Health is set out in the replies of Sir Walter Kinnear

to Questions 23,648-23,650 and 23,666-23,681, from which we quote the following :—

> " Although exempt persons are a small class and require special administrative arrangements, I think the abolition of the class would hardly be justifiable. Exemption is useful for many persons who, although employed within the meaning of the Act, are not regularly employed, or are already provided for in case of sickness, and it thus provides a certain elasticity in a compulsory scheme. The obligation of employers to contribute for such persons should also be maintained. Although in practice there might not be much risk of discrimination in favour of employing exempt persons if no contributions were payable, there might be a tendency in some cases in this direction, and it is a sound principle that the employer should have to pay his quota to the funds according to the labour which he employs, without regard to the individual circumstances of the employees. . . . I am inclined to think that as these persons have been entitled to medical benefit for some years, and the statistics go to show that the great majority of them do take advantage of the medical benefit which is provided for them, to deprive these persons of the benefit which they have enjoyed for so many years would be rather a retrogade step, and, on the whole, I think employers would agree that, as they are required to pay contributions, it is only right that those contributions should be applied in the interests of the health of their employees. . . . "

531. The Federation Committee of the English, Scottish and Welsh Associations of Insurance Committees (App. XXXVI, 170-173) and the British Medical Association (App. XLVII, 15 (*b*) ; Q. 14,891-14,893 and 14,923) think that the right to medical benefit should be withdrawn ; while the Scottish Association of Insurance Committees (App. XXXVII, 76 and 93) suggest that the contributions paid in respect of exempt persons should be paid to the General Purposes Funds of Insurance Committees. The Standing Committee of Scottish Insured Women urge the abolition of the class, and suggest that if it is retained the title to medical benefit should be withdrawn and the contributions paid into the Central Fund for the benefit of the members of all Societies (App. XLVI, 12 ; Q. 14,530-14,531).

532. After full consideration of the subject we are of opinion that the class should be retained with the present arrangements. It provides in many cases a useful niche for that class of persons who will probably be subject to compulsory insurance only for a short period and who do not in that period desire to become members of Approved Societies. These persons are not in need of the cash benefits ; but the medical benefit gives them something which is valuable and which they appear to appreciate.

We have no indication that employers have objected to the arrangement under which they pay the contribution, and although we do not think there is very much substance in the argument that an employer would give preference to persons with private incomes if he had not to pay a contribution, the system provides a useful answer to such a criticism. We do not think that exempt persons should be deprived of medical benefit which they have enjoyed for 11 years. To do so would be deliberately to go back on the provisions of the 1913 Act, and we share the view of the Ministry of Health that any removal of medical benefit from those who have enjoyed it would be a retrograde step.

533. We suggest one small amendment in the system. At present, where the total income of an exempt person, from all sources, exceeds £160 a year, he is required to make his own arrangements for receiving medical treatment and attendance. This was the income limit in the 1913 Act, and it was not raised in 1918 to meet the depreciation in the purchasing power of money when all the other figures were raised by, approximately, 50 per cent. We understand that this was due to the feeling of the medical profession at the time that there should be as little extension of contract practice as possible. We think, however, that in view of the limits otherwise provided in the system, this limit should now be raised to £250 per annum.

Men Serving in the Forces of the Crown.

534. Men serving in the Armed Forces of the Crown are required to be insured under the National Health Insurance Act, but, inasmuch as their service pay continues during illness and full medical attendance is provided by the Service Authorities, the only insurance benefit to which they are entitled is maternity benefit. The contribution payable is $3\frac{1}{2}d.$ a week, the whole of which is paid by the Service Departments. This contribution, in addition to covering the cost of maternity benefit, provides the funds required to enable the men on discharge from the Forces to continue in full insurance as civilians. No contribution cards are used during service, but the contributions are paid in bulk by the Service Departments to the National Health Insurance Fund and are credited to the appropriate Approved Societies on the basis of a record, obtained from each man on his enlistment, of the Approved Society of which he is a member.

535. It was stated in evidence given on behalf of the Ministry of Health that this system gives rise to some administrative inconvenience, owing to the difficulty of obtaining from a man on his enlistment correct particulars of his Approved Society (*Kinnear*, Q. 373). Many men are found on discharge to have been members of Societies, although on enlistment they stated

that they did not belong to any Society. This results in the Society not being credited year by year with the contributions payable in respect of the man during his service and an adjustment becomes necessary on the man's discharge. Moreover, the Society, not having been notified of the man's enlistment, will have treated him as having gone out of insurance and will have been debited with the transfer value.

536. On account of these administrative objections to the present system, we have considered the expedience of suspending men from insurance altogether on enlistment and re-instating them in insurance when they again take up civilian employment after discharge.

537. One difficulty which would arise under this plan is that in the absence of provision for the automatic re-admission of these men to their old Societies on discharge, such a procedure would entail the loss of acquired rights to additional benefits, a consequence which in certain cases would represent a considerable hardship. On the other hand, if provision were made for their re-admission, it would be necessary for the Department to keep a record of the Societies to which the men belonged at the time of enlistment, and this would present very much the same difficulties as arise under the present system. An even more serious difficulty would arise in respect of men discharged prematurely as invalided. Compulsion on their own Societies to readmit such men could not be justified, with the result that many would permanently lose the advantages of Society membership.

538. There is a further difficulty in the way of the adoption of the proposal to suspend insurance during service. At present, under the Insurance Act, maternity benefit is paid on the confinement of the wives of serving men, although, as we have seen, the insured person pays no contributions during service. If it were, in effect, proposed to place men in the Services wholly outside the Insurance Scheme, it would obviously be necessary to make some provision for a corresponding payment from another source in lieu of the maternity benefit, of which the new arrangements would deprive them. We are informed, however, that the Service Departments, on whom the responsibility for making such payments would naturally fall, do not view such a proposal with any favour.

539. The evidence given by Approved Societies on this subject was not all in one direction. The Hearts of Oak Benefit Society suggested (App. IV, 134-143; Q. 3259-3312) the suspension of insurance during service, but the Joint Committee of Approved Societies were opposed to the proposal (App. XIV, 46), as was also the Manchester Unity of Oddfellows, who expressed the opinion that the present system is satisfactory on the whole, and

should be retained. (App. VII, 76; Q. 5906-5920.) This latter Society has several important Branches established for, and consisting largely of, serving men, and its views are naturally influenced by the effect which the proposal would have upon these Branches. Other Societies with Branches are, to a lesser extent, in the same position.

540. After due consideration of the arguments for and against the proposal, we have come to the conclusion that the proposed change would probably give rise to difficulties at least as great as, though different in kind from, those arising under the present system, and we therefore recommend that no change should be made.

541. There is one further matter in connexion with the insurance of men of the Forces to which our attention has been directed. During their service, any of these men who are not members of an Approved Society become in effect members of the Navy, Army and Air Force Insurance Fund and receive from that Fund the only benefit, viz., maternity benefit, to which they are entitled while serving. On discharge from the Forces it is open to any man of this class to apply for membership of any Approved Society, but if by reason of the state of his health he is not able to obtain admission to a Society, he then becomes permanently a member of the Navy, Army and Air Force Insurance Fund and becomes entitled to receive out of that Fund all the normal benefits of the Act, but not any additional benefits. If he becomes a member of an Approved Society he does not become entitled to participate in any additional benefits provided by the Society until after the waiting period applicable to insured persons transferring from one Society to another. We have received a statement from the Secretary of State for War on behalf of the three Service Departments submitting two suggestions for improving the position of men discharged from the Forces as regards title to additional benefits (App. CXXIX). These suggestions were (1) that the benefits payable out of the Navy, Army and Air Force Insurance Fund to discharged men who are established as permanent members of the Fund should not in future be confined to the normal benefits of the Act, but should include also additional benefits equivalent to the average of those provided by Approved Societies in general; and (2) that men who join Approved Societies on their discharge from the Forces should not be subject to the ordinary waiting period before becoming entitled to additional benefits.

542. We are informed that the financial position of the Navy, Army and Air Force Insurance Fund (the solvency of which is guaranteed by the Service Departments) is so satisfactory that it can well afford the cost which would be involved in giving effect to the first of these two suggestions, and that there is a sufficient margin in the contribution payable during service to

provide reasonably for the second. We are also satisfied that there is ample justification for the proposition that the insurance rights of men who have served with the Forces of the Crown should be improved in the manner suggested and we, therefore, recommend that statutory provision should be made accordingly. In the case of men who transfer to Approved Societies on discharge from the Forces, we consider that the new provision should take the form of requiring them to be treated for the purpose of title to additional benefits as though they had been members of the Society from the date of their joining the Forces and that to enable this to be done the transfer values payable out of the Navy, Army and Air Force Insurance Fund should be augmented by the estimated share of surplus earned during their period of service.

Mercantile Marine—Foreign-Going Seamen.

543. The original intention of the National Insurance Bill of 1911 was to segregate in one Society all foreign-going seamen of the Mercantile Marine. Owing, however, to some conflict of opinion between the leaders of the various interests concerned the efforts made in this direction were unsuccessful, and we are informed that the 100,000 foreign-going seamen insured under the Act are distributed over about 1,600 different Societies and Branches (*Kinnear*, Q. 23,769). The Seamen's National Insurance Society has about 40,000 foreign-going seamen members and the National Sailors' and Firemen's Union about 20,000, while of the remaining 40,000, 24,000 are in seven different Societies. We understand that the difficulties in the way of forming a single Society for these men have hitherto proved insurmountable, and that the main obstacle has been the rivalry of the two large Societies which have between them 60 per cent. of the total membership of foreign-going seamen.

544. The foreign-going seamen are undoubtedly a difficult class to deal with, owing to the nature of their calling, and many of them are indifferent as to the surrender of cards. We were informed by Sir Norman Hill (App. XXXI, 14) that the leakage of contributions in the case of the Seamen's National Insurance Society was between 25 and 33 per cent., and we are given to understand that a Departmental Committee which recently considered the problem, while not accepting this figure, were satisfied that the loss was substantial and far in excess of that amongst landsmen.

545. Having regard to this considerable loss we have given careful consideration to the suggestion made by the Seamen's National Insurance Society (App. XXXI, 40-42; Q. 12,060-12,071, 12,086-12,089 and 12,146-12,165) and the National Sailors' and Firemen's Union (App. XLIII, 16; Q. 13,977-13,985 and 14,037-

14,040) that the collection of contributions in the case of foreign-going seamen should be made not by the stamping of cards but on a schedule system. Under such an arrangement the paying-off officer on each vessel would be responsible for handing to the Superintendent of the Mercantile Marine a schedule giving full particulars of each seaman and the period of the voyage, and the contributions in respect of the seamen included in the schedule would be paid in cash to the Central Department, who would, in turn, be responsible for transferring credit to the appropriate Societies through a clearing-house established for the purpose. We examined Sir Walter Kinnear as to the practicability of this proposal, and quote from his reply :—

> "I have read carefully the evidence given by Sir Norman Hill to the Commission and I am inclined to think that the estimate of loss of contribution income for foreign-going seamen given by him is excessive, but there is no doubt that a substantial loss in fact occurs through failure of the contribution cards to reach the Societies. We think the system might be altered on the lines of the schedule system suggested by Sir Norman Hill; indeed it has become a matter of more moment since the introduction of the Contributory Pensions Scheme of this year. . . . It is suggested that in place of the collection of contributions by cards the contributions of foreign-going seamen should be paid in a lump sum with a schedule on the termination of each voyage. The dissection of the schedule and the credit to Societies would be made by some Central Clearing House of which Societies having a substantial seamen membership would defray the cost. I should like to bring under the notice of the Commission, the fact that this would be a fairly difficult machine to administer because these foreign-going seamen at present are distributed over about 1,600 to 1,700 different Societies and branches. Of course, the great bulk of them are in a very limited number of Societies, but that is one of the problems which we shall have to face in introducing this new system." (Q. 23,767-23,769.)

546. We are convinced that such a system would undoubtedly eliminate to a large extent the present leakage of contributions and in addition would be much more convenient to the shipowners. No new statutory powers would be necessary in order to put the system into operation. We are assured that such a scheme would prove workable, and that effective safeguards could be taken to ensure that contributions were credited to the proper Societies.

547. We recommend accordingly that in the case of foreign-going mercantile marine members the card system of collecting contributions should be abandoned, and a schedule system

instituted on the lines referred to above. We think that in view of the magnitude of the work of allocating the contributions to Societies the responsibility of the Central Department's clearing house in this matter should be limited to those Societies having a reasonably large membership of mercantile marine members and that all other Societies and Branches having members of this class should be required to lodge a claim on the Department for the contributions paid in respect of the members. The cost incurred in crediting Societies with contributions on this basis should be borne *pro rata* by the various Societies concerned.

548. The proposed schedule system for the collection of contributions would apply only to contributions payable in respect of service in the foreign trade, since an essential part of the system is the paying-off of the crew in the presence of a Superintendent of the Mercantile Marine, and the verification by him of the amount properly payable as Health Insurance contributions—a procedure not followed in the case of ships engaged in the home trade. In this connexion we foresee some difficulties to which the adoption of the schedule system may give rise. A very large proportion of foreign-going seamen are not employed solely in the foreign trade throughout each year, but have also periods of service in the home trade, or of employment on shore. For these periods contributions will continue to be payable in the ordinary way by the affixing of stamps to half-yearly cards which will be issued by the Societies and, when stamped, will have to be returned to the Societies by the seamen. For all these men, therefore, the Societies will be compelled to keep separate records of contributions paid under each system. There will also be the danger that men who in respect of their normal employment on foreign-going service are absolved from the responsibility of taking any steps to see that their contributions are properly credited to their Societies, will become more lax in taking the steps which will still be necessary as regards the contributions payable in respect of service in the home trade, or employment on shore. Unless the Societies make special efforts to impress upon their seamen members the importance of their responsibilities in this latter respect, there will be a risk that any improvement in the collection of contributions in respect of foreign-going service which may result from the adoption of the schedule system, may be offset by a loss of income to the Societies in respect of employment of their members in the home service or on shore.

549. We have also given careful consideration to the question of the possibility of compulsorily transferring all seamen to one Society, but we feel that notwithstanding the advantages that would ensue the difficulties in the way of enforcing such an arrangement would in all probability prove insurmountable. Any such unification must, we think, be left to the Societies

themselves and we are told that there is already a movement in this direction so far as the two largest Societies for seamen are concerned.

550. While we regard it as unfortunate that insured persons of this class are scattered among so many Societies we do not recommend that definite provision should be made for their segregation in one Society. We consider, however, that the Department should keep this in view as an ideal desirable of attainment, and that they should wherever practicable, exercise their powers of persuasion in order to approach that end.

551. A further matter relating to seamen of the Mercantile Marine to which our attention was directed, was the special arrangements for the provision of medical benefit to members of the Seamen's National Insurance Society. It is provided by Section 63(5) of the Act that the medical benefit of members of this Society shall be administered by the Society itself instead of by Insurance Committees, and in accordance with this provision the Society makes arrangements with doctors in the leading ports for attending any members of the Society who may require medical attendance. The Society accordingly are not debited, like all other societies, with payments to Insurance Committees in respect of medical benefit, but themselves pay out of their own funds the doctors who attend any members of the Society. For this purpose a scale of fees on an attendance basis has been agreed between the Society and representatives of the medical profession and is revised from time to time. Full particulars of the arrangements are set out in Appendix XXXI, 32. The Society desire that these special arrangements should be continued, but on the other hand, we have received evidence from a number of sources that there was no necessity for the continuance of the arrangements and that members would be at no disadvantage by being placed in the same position as all other insured persons as regards arrangements for medical benefit. For example, the National Sailors' and Firemen's Union, the membership of which is also almost exclusively composed of seamen of the Mercantile Marine, say :—

"As far as we know, the ordinary medical benefit arrangements work as well for seamen as for any other section of insured persons. I do not remember receiving any complaint that any of our members could not get medical attention whenever it was required through any fault in the medical benefit arrangements. As far as our experience goes there would appear to be no reason for any special arrangement regarding the medical benefit of men employed in the Mercantile Marine." (App. XLIII, 21.) Again, the Federation Committee of the Associations of Insurance Committees speaking on behalf of all the Insurance Committees of the country make the following statement :—

"In the early days of the insurance medical service there may have been some reason for separate arrangements, but in view of the modifications since made to meet the needs of temporary residents and travellers, and the development of the collective responsibility of insurance practitioners to provide treatment (including emergency treatment), the initial reasons no longer exist for the exceptional arrangements for members of this Society which do not extend to persons in the mercantile marine who join other Approved Societies." (App. XXXVI, 168.) We also questioned the representatives of the Ministry of Health on the subject, and the following reply indicates the views of the Ministry:—"Since medical benefit was first instituted, the arrangements for the treatment of temporary residents and the recognition of the right of any insured person to treatment whether on the list of a doctor or not, make it, in our view, unnecessary to continue the exceptional treatment of the Seamen's National Insurance Society. A large number of foreign-going seamen are members of other Societies, and, as far as I know, there is no evidence that these persons experience any difficulty in obtaining whatever treatment they need under the ordinary provisions of the Act." (*Brock*, Q. 23,995.)

552. We are satisfied that whatever may have been the position at the inception of the Scheme there is no longer any necessity for special arrangements for the medical benefit of members of the Seamen's National Insurance Society and we, therefore, recommend that these arrangements be discontinued and that members of the Society should in future receive their medical benefit under the normal arrangements.

553. It was urged upon us by the Seamen's National Insurance Society (App. XXXI, 43) and the National Sailors' and Firemen's Union (App. XLIII, 26) that an increased rate of administration allowance should be made to Approved Societies in respect of members serving as foreign-going seamen. We do not consider that any such claim should be allowed, as it would open the door to similar claims in respect of other classes of insured persons. In any case the position would probably be met by the adoption of the revised system of collecting contributions which we have suggested.

The Lascar Fund.

554. It may be convenient to deal here with certain suggestions which were made to us by Sir Norman Hill when giving evidence on behalf of the Special Fund for Seamen, commonly called the Lascar Fund (App. XXXII; Q. 12,178-216). This is a Fund derived from the contributions payable by shipowners in respect of seamen having no domicile in the United Kingdom, and the fund is used for providing pensions to men between 65 and 70 years of age who have had long sea service. These pensions are at present restricted to members of Approved Societies.

and the first suggestion made to us was that this restriction should be removed and that the pensions should be thrown open to all seamen domiciled in the United Kingdom who have served in the British Mercantile Marine. On this proposal Sir Walter Kinnear made the following comment :—

> " Many seamen cease, on account of age and infirmity, to go to sea for a prolonged period, and if they do not take up insurable employment on shore, their insurance and Society membership have ceased before they reach pension age. An example is the crofter seaman of the Hebrides who has left the sea for several years and maintains himself by cultivating his croft. We have also the case of officers and engineers in the Mercantile Marine who are excepted from insurance by the remuneration limit and are not members of Societies. The contributions forming the income of the Lascar Fund are those paid by the employers for foreign seamen, not domiciled in the United Kingdom, who are not insured. They are, therefore, in the nature of a general tax on the running of the ship, and may be held in equity to be utilisable for the benefit of all British seamen, and not merely for the class who happen to be members of Approved Societies. . . . That proposal has already been adopted by the Ministry of Labour as regards pensions derived from Unemployment Insurance contributions, and we therefore recommend that this particular request be granted." (*Kinnear*, Q. 23,771.)

555. We are satisfied that there is a good case for the suggested change, and we therefore recommend that Section 64 (4) of the Act should be amended by the omission of the words " being members of Approved Societies."

556. The second suggestion made to us with reference to the Lascar Fund was that the cost of administering the Fund, which under the Act has to be apportioned amongst Approved Societies whose members are entitled to the benefits, should be borne by the Fund itself. On this suggestion, Sir Walter Kinnear said :— " It would be very difficult to levy Societies in that way. As a matter of fact, that Section of the Act has never yet been put into operation. Societies have considerable difficulty in ascertaining precisely their seamen membership. We think it is hardly reasonable to charge Societies with the cost of administering the Pensions Scheme, and it is therefore suggested that Section 64 (5) of the Act should be amended to provide that the cost of administration should be borne by the Lascar Fund itself." (*Kinnear*, Q. 23,771.)

557. We are satisfied that this also is a desirable change, and therefore recommend that Section 64 of the Act should be amended accordingly.

558. There is one further matter in connexion with the Lascar Fund which was not specifically raised before us in evidence, but to which we think it necessary to call attention. The Fund is at present used to provide pensions to ex-seamen between the ages of 65 and 70. Under the Widows', Orphans' and Old Age Contributory Pensions Act, however, the State has now made provision for old age pensions from the age of 65, and no contribution towards the cost of these pensions is made by shipowners in respect of seamen not domiciled in the United Kingdom. On the other hand, under Section 64 (5) of the National Health Insurance Act, the ordinary proportion of the cost of pensions awarded out of the Lascar Fund is payable by the State. We are not aware in what way the scheme of seamen's pensions will be amended on the coming into operation of old age pensions at 65, but in any case we do not consider it a fair and reasonable arrangement that, in the circumstances referred to above, the Exchequer should be called upon to contribute towards the cost of pensions and other benefits awarded out of the Fund, and we recommend, therefore, that the State grant in respect of such pensions and benefits should be withdrawn.

SECTION E.—VALUATION OF SOCIETIES AND PROVISION OF ADDITIONAL BENEFITS.

Valuation of International Societies.

559. Suggestions were made to us on behalf of the Ministry of Health for the amendment of various statutory provisions with regard to the valuation of Approved Societies. The first of these related to what are ordinarily known as "International Societies"

560. Section 83 (3) of the 1911 Act provided that Approved Societies which operated in more than one part of the United Kingdom were to be valued separately in respect of each country in which members were resident. They were thus required to be treated for accounting and valuation purposes as though the members resident in each country formed a separate Society, and this provision was applicable even to Societies with a wholly unified administration centred in that country in which the head office—or it might be the only office—was situated. Section 16 of the 1913 Act repealed this provision, but conferred upon members in countries other than that in which the head office of the Society was situated an option to be exercised within a limited period of six months whereby, if they so desired, they might elect to continue to be separately valued. Section 3 (7) of the 1918 Act renewed the option for a further period of six months. At the same time an opportunity was also given to the members resident in any country for which a separate valuation had been retained to reverse their decision with the consent of the central governing body of the Society.

561. It has been suggested to us (*Kinnear*, Q. 23,651) that in view of the difficulties which arise in the case of persons who remove from one part of the United Kingdom to another while retaining their membership in the same Society, national sections of Societies which are separately valued should be given a further opportunity, if they so desire, of having in future a combined valuation. We have also considered the converse proposition that international Societies with a single valuation should be given the option of separate national valuations.

562. We consider that there are very strong arguments in favour of giving to international Societies a further opportunity of electing to have a combined valuation for the various countries in which they operate. We are impressed by the fact that in the type of case we are considering there is no separate administration in respect of those portions of the Societies which are subject to separate valuation, and we feel that so long as a common administration is responsible for the conduct of the affairs of the whole Society, there should ordinarily be a common sharing of the contingencies against which the members are insured. We understand, also, that when additional benefits first became payable it was ascertained that the effect of the Act and the Regulations was to place a member of such a Society changing his residence from one country to another in the same position, so far as concerned additional benefits, as a person who had changed his Society, thus depriving him for a time of his title to additional benefits. While Regulations have now been framed to obviate this hardship to the individual, it has been necessary, in applying them, to disregard certain financial considerations which ought to have weight. We think, moreover, that the present conditions which require the maintenance of separate funds for the separately valued national sections and the passing of transfer values in all cases of migration must seriously complicate the task of administration and add to its cost, without securing any adequate corresponding advantage.

563. On the question of allowing unified Societies to establish separate funds on a national basis, our opinion is equally definite. We think that combined valuation is now the normal principle, and that the right of election for separate valuation is no longer admissible. We do not, therefore, consider that in the future any option should be given to international Societies to make such a constitutional change as would enable them to be valued separately in respect of each part of the United Kingdom in which they carry on business.

Associations of Approved Societies.

564. Under the 1911 Act all Approved Societies which, at the date of valuation, had less than 5,000 members, were required, for the purposes of meeting deficiencies revealed on

valuation, to be associated with other Societies in an Association formed for the purpose, or if they had not joined any such Association, to be compulsorily grouped on a geographical basis. The 1918 Act amended these provisions, and the existing enactment provides for the approval of Associations of Societies formed for mutual assistance against adverse results on valuation by means of a pooling of the Contingencies Funds of the constituent Societies. The Association in effect acts as a Society, and the constituent Societies as its branches for the purpose of dealing with surpluses and deficiencies. The Act further provides that in the case of Societies with less than 1,000 members which have not at the date of valuation joined a recognised Association, any balances of the Contingencies Funds not required for making good deficiencies in the Societies themselves are to be applied *pro rata* to such an extent, not exceeding one-half, as may be necessary towards making good the balances of the deficiencies remaining in the case of other Societies of this class.

565. We are informed that no case has arisen in which it has been necessary to put into operation the main provision for which Associations were formed. (*Kinnear*, Q. 594 and 23,598.)

566. While we recognise that statutory Associations fulfilled a useful purpose under the original scheme, we consider that their main function is now rendered unnecessary, having regard to the adequate protection afforded to small Societies by the financial provisions relating to the formation of Contingencies Funds and the Central Fund.

567. We accordingly recommend that the provisions of Section 76 of the Act, enabling Associations to be formed for the pooling of Contingencies Funds, should be repealed. At the same time, we see certain advantages in allowing Associations of Societies to continue on a voluntary basis for purposes of consultation and general co-operation in the work of the Insurance Scheme, and we have no desire to interfere with the continuance of such Associations, should they see fit to continue in existence on a wholly voluntary basis for the purpose of affording each other mutual counsel on questions that may arise.

Period of Schemes of Additional Benefits.

568. The next matter to which our attention was directed was the period of operation of schemes of additional benefits provided out of a surplus disclosed on valuation. (*Kinnear*, Q. 23,651.)

569. Section 75 of the Act provides that where, on the valuation of a Society or Branch, there is found to be a surplus which is certified by the valuer to be disposable, the Society or Branch may submit to the Minister a scheme of additional benefits for his approval. The Section fixes no limit to the period of currency

of any scheme so submitted, and the present limitation of the period to five years rests solely on provision made in the scheme itself, as submitted to the Minister by the Society or Branch.

570. It has been suggested to us that it is desirable to place a definite statutory limit on the period for which a scheme of additional benefits should continue to operate. Under the existing provisions of the Act there is nothing to prevent a scheme operating indefinitely, subject to a provision suspending its operation if a deficiency is disclosed on a subsequent valuation. But the period over which the benefits of a scheme will extend constitutes an essential element in fixing the rates of those benefits, and consequently no scheme can be framed until its duration has been first determined, and the necessary data for the actuarial calculations thus completed. In these circumstances, it has been found necessary to require Societies to include the period for which the scheme is to run as an essential condition of any scheme submitted for the approval of the Minister. It has been suggested that a matter of such importance ought not to be left for regulation in this indirect manner, and that the Minister should be explicitly vested by the Act with the necessary powers.

571. We agree that the incorporation of this condition in the Statute is desirable, and we recommend accordingly that provision should be included in Section 75 of the Act which will limit the period of currency of schemes for the distribution of additional benefits to such period as may be fixed by the Minister.

Proportion of Surplus Certified as Disposable.

572. It was brought to our notice (*Kinnear*, Q. 23,651) that difficulty had arisen with regard to the large amounts of surplus which in many cases had been certified as disposable on the second valuation of Societies. The recent experience of the great majority of the Societies and the profit margins in sight in regard to their future working were such as to lead the Valuers to the conclusion that in these cases the whole of the surpluses shown were disposable. On the other hand, it had been decided, for sound administrative reasons, that the additional benefit schemes to be made after the valuation should be limited to a period of five years, and it was clear that if the disposable surpluses resulting from a period of great and, as it well might prove, exceptional prosperity were allowed to be spent in a single quinquennium there might be a grave risk of the additional benefits being generally raised to a level at which they could not be permanently maintained. Such an eventuality might occasion considerable disappointment in future to the insured classes, and might further entail a serious measure of disorganisation in so far as arrangements might have been entered into for the provision of treatment benefits. In these circumstances an arrangement was made between the Ministry of Health and the Scottish Board

of Health, and the Government Actuary, in pursuance of which the valuers, in addition to certifying the disposable surpluses, informed the Societies of the amounts to which it would be prudent to limit expenditure under schemes with a currency of five years. The assent of the Minister, or the Board, as the case may be, has accordingly been given to schemes framed on these lower amounts, leaving the balances of the disposable surpluses to be carried forward to assist in the maintenance of additional benefits in the future.

573. It is evident that if the currency of schemes of additional benefits is to be definitely limited to a fixed period, a Society, in preparing its scheme, will primarily require to be informed of the amount of surplus which it can safely spend in that period, and it has been suggested that in arriving at this amount regard should always be had to the considerations advanced in the last paragraph. From this point of view the disposable surplus would be the amount which in the opinion of the valuer could properly be expended during the currency of the scheme. To enable the valuer to give a certificate carrying this meaning it would be necessary for the Act to indicate the conditions to which he was to have regard in giving his certificate. In this respect the Act is at present silent, and the valuer must certify the full amount of the surplus which he considers disposable, even though it would be the height of imprudence for the Society to frame a scheme under which the whole of the surplus would be distributed in the years immediately following the valuation.

574. We are satisfied that it is desirable to make provision in the manner suggested, and we recommend that Section 75 of the Act should be amplified so as to provide that the Treasury valuer, in certifying what part of a realised surplus is disposable, shall have regard to the probability of the continued maintenance of any additional benefits to be provided in the scheme next to be made.

Revision of Schemes of Additional Benefits.

575. There is no provision in the Act itself which enables the Minister, once he has given approval to a scheme of additional benefits, to require a Society to review that scheme even though such a review may become highly desirable in the light of experience gained during the period of the five years for which the scheme operates. We are informed that in so far as schemes arising under the second valuation are concerned a clause to the following effect has been inserted in every scheme :—

> " If at any time during the currency of this scheme the Minister declares that he is satisfied in the light of experience of the administration of additional benefits by Approved Societies generally that it would be to the advantage of insured persons participating in those benefits that further

or other conditions should be attached to the administration of any of the benefits comprised in this Scheme, the benefits shall be administered by the Society as if those conditions had been incorporated in and formed part of this Scheme."

576. We do not, however, regard it as satisfactory that a provision of so important a nature should rest upon no higher authority than a clause in a Society's scheme. Having regard to the large sums which are now available for distribution in the form of additional benefits, we consider that all schemes should be subject to regulations in force at the time and that the Minister should be empowered to make and amend those regulations as and when necessary, and we recommend that Section 75 (2) should be amended accordingly.

Eligibility for Additional Benefits.

577. It is provided by Section 75 (4) of the Act that "additional benefits shall not, except as otherwise prescribed, be distributed among any persons who were not members of the Society or branch on the date as at which the valuation was made." The regulations made under the Section provide that persons who have been members continuously for a period of five years may be entitled to participate in additional benefits, notwithstanding that they were not members on the date as at which the valuation was made.

578. It has been suggested to us (*Kinnear*, Q. 23,651) that the Section as worded is not satisfactory inasmuch as it does not state in positive form the persons who must be allowed to participate in the additional benefits provided by any Approved Society, but merely lays down certain limitations on the power of Societies to provide in their schemes what persons are to be so entitled.

579. We think that the qualifying conditions for participation in additional benefits should be uniform in all Societies and should be laid down in the Act itself or in regulations. On the whole, and particularly in view of the possibility of the conditions having to be varied from time to time, we think that they should be contained in regulations and we, therefore, recommend that Section 75 (4) of the Act should be amended so as to provide that the conditions under which persons shall be entitled to participate in additional benefits shall be such as may be prescribed.

580. Our attention was directed by several witnesses to the present arrangement under which the title to participate in additional benefits does not accrue until the beginning of the fifth year after that in which an insured person joins a Society either as a new entrant into insurance or by transfer from another Society. In the latter case in particular it appears to us to be open to serious criticism that the theoretical right of free choice

of Society should be fettered by the fact that a person transferring from one Society or Branch to another loses additional benefits for a substantial period of time. It is true that the new Society is not under any obligation to accept the member, nor is the member under any compulsion to leave. Nevertheless there must be many cases when a change of residence makes it wholly reasonable that an insured person should desire to transfer his membership to another organisation, and in consequence considerable hardship must not infrequently be inflicted. But apart from cases where the desire to transfer arises from a change in the insured person's residence, it must be remembered that the Act contemplates that insured persons should enjoy, subject only to such safeguards as may be necessary, a liberal right to transfer, when they so desire, from one Society to another willing to accept them. It appears to us *prima facie* indefensible that the exercise of a fundamental right conferred by the Act should entail any greater loss than is inevitable.

581. The evidence we have received on this subject varies. The hardship is generally admitted, but the difficulties of giving the transferring member either the additional benefits of the new Society or those of the old are pointed out. The administration of Societies is already so complicated as to make it on the whole undesirable that they should have to administer different schemes of additional benefits for different members. On the financial side, the necessity for having the transfer values loaded to meet the cost of additional benefits has to be considered. If, on the other hand, the benefits granted are to be those of the new Society, it is clear that the old Society cannot be expected to pay for them. In this event there is a serious risk of the financial soundness of a Society being impaired by an active policy of canvassing for members.

582. Another very important point has been put to us in connexion with the treatment benefits. It seems very undesirable that a person who has enjoyed treatment benefits, for example, dental benefit, in one Society should lose this for a lengthy period on transferring. Even more important is the fact that young persons, who may have been receiving dental treatment at school will, for a period of seven years, i.e., the two years from 14 to 16 and the five waiting years, be unable to qualify for this important benefit. (*British Dental Association*, Q. 9227).

583. The Hearts of Oak Benefit Society (App. IV, 333-339; Q. 3756-3757) desire the retention of the waiting period, but realise the importance of dental benefit between the ages of 16 and 21. They suggest that it should, partly for this reason, be made a statutory benefit. (App. IV, 255-284.) They also concur in the view that it would not be practicable to give a transferring member a title to the same additional benefits as he received from his former Society. The

Ancient Order of Foresters (Q. 4389-4390) recommend the retention of the waiting period on the ground that " it is a healthy condition of things that a member, entering a Society, should serve a certain period, approximating to the quinquennium, before he becomes entitled to such additional benefits as the Society he joins is paying. It is true that a person entering insurance for the first time and a person transferring from another Society are not on the same footing in that respect. But I think that is covered by the fact that nobody is really compelled to transfer, although it may be to their advantage and convenience." The National Conference of Industrial Assurance Approved Societies (Q. 5236-5238) are of the same opinion, and think that there is no evidence of hardship resulting from loss of additional benefits on transfer. The Independent Order of Oddfellows, Manchester Unity (Q. 5738-5741, 5982-5983, 6088-6097), also say that they have no complaints, and think that any loading of the transfer value would lead to great complications. The United Women's Insurance Society favour the abolition of the waiting period and consider that there is no objection to a loaded transfer value for the cash benefits, and state that the ordinary transfer value would be accepted by them for the non-cash benefits. (App. XXIV, 13; Q. 10,186-10,188, 10,197-10,199, 10,239.) The Stock Exchange Clerks' Health Insurance Society (App. XV, 5; Q. 8446-8447, 8481-8486, 8553-8565) are also in favour of immediate title in the new Society to additional benefits on the scale of the old Society. The Independent Order of Rechabites (App. VIII, 36) are willing to have a modification in the case of transfers between Branches of the same Societies. The Public Dental Service Association (Q. 9794) point out that the five years' waiting period is a serious handicap to good dentition. The National Association of Trade Union Approved Societies state (Q. 22,073) that " there is no freedom of choice of Society while the insured person forfeits his right to additional benefits. As most Societies are giving additional benefits, transfers are almost impossible." The Standing Joint Committee of Scottish Insured Women suggest (App. XLVI, 27; Q. 14,550-14,551) that the waiting period should be reduced to two years.

584. The evidence from the Ministry of Health was to the effect that, on the whole, the difficulties of the loaded transfer value and the administration of different scales of cash benefit are so great that, in spite of the hardship, the present Scheme should be retained, so far as the cash benefits are concerned; but they suggest that the title to treatment benefits, in the case of those entering into insurance for the first time or transferring from one Society to another, should mature at the beginning of the third year, thus giving a $2\frac{1}{2}$ years' waiting period, on the average. A Society has a limited fund for treatment benefits,

and this would provide for the small number of transferring members until it was exhausted. (*Kinnear*, Q. 652-655, 672-693, 23,729-23,748.)

585. We have given this matter our most careful consideration. We are satisfied that the present arrangements impose too severe a penalty on transfer from one Society to another, and should, therefore, be modified. At the same time, we are impressed by the arguments put before us by the Ministry as to the dangers of widespread canvassing for transfers which would be likely to result from the granting of immediate title to additional benefits on transfer. We also recognise that the granting of this right would necessitate the loading of the transfer value, and we are advised that actuarially this would involve very serious difficulties, regard being had to the variations in the scales and range of additional benefits and to the fact that the dates of transfer would bear no relation to the periods for which the schemes of additional benefits of the various Societies were current. We have considered whether the suggestions put forward by the Ministry and referred to in the preceding paragraph would provide a reasonable solution of the problem, but we have come to the conclusion that they do not go far enough. We see no sufficient reason for any change in the present position as regards title of additional benefits for new entrants into insurance, but in the case of persons transferring from one Approved Society to another we think that the title to participate in all additional benefits—whether cash or treatment benefits—provided by the new Society should mature at the end of two years after the date of transfer, and we accordingly recommend that this change should be made.

586. We are of opinion that the waiting period of two years will provide sufficient protection against the evil of undue canvassing for transfer.

587. We recognise, however, that even with this limitation the financial position of a Society might be seriously prejudiced if the number of persons admitted to membership by way of transfer were allowed to reach a substantial proportion of the total membership of the Society, unless the transfer values had been increased to cover the extra liability imposed by the grant of additional benefits. We are anxious to avoid such adjustment of the transfer values, partly for the reasons given above and partly because we cannot contemplate that the Society which a person leaves should be charged with the value of additional benefits on the scale given by the Society to which he goes. To provide a safeguard against this risk, we recommend that the Minister should be given power to suspend the right of any Society to accept members by way of transfer if the membership of the Society has been increased in this way since the date of the last valuation by more than a prescribed proportion fixed in accordance with actuarial advice.

588. In the case of transfer between Branches of the same Society, where in practice no transfer of membership is likely to arise unless the member moves from one locality to another, we think that it might be left optional to the Societies to allow the title to participate in the additional benefits of the new Branch to be given immediately on transfer. In the special circumstances indicated it is unlikely that the financial position of any Branch accepting transfers would be sensibly affected by this concession.

589. There is one type of case in which we think that a special exception might be made to the normal provision as to title to participate in additional benefits. We have referred in paragraph 461 to certain classes of insured persons, such as bank clerks, insurance officials and the like, who normally pass out of insurance at a comparatively early age by reason of their rate of remuneration rising beyond the limit of £250 a year. These persons are mostly congregated in a few Approved Societies formed specially for their benefit, and these Societies, by reason of the character of their membership, which results in low benefit claims, have large surpluses on valuation. The anomalous position then arises that before a scheme of additional benefits has been brought into operation or during its currency, many of the persons who, as members of the Society, contributed to build up the surplus pass out of insurance and are consequently no longer eligible to participate in the benefits.

590. It was suggested to us by Mr. Duncan Fraser, giving evidence on behalf of the Royal Insurance Officials' Benevolent Association, that in order to deal with this position there should be a special extension of the period during which title to additional benefits should continue after the cessation of insurable employment (App. XXVII, 20; Q. 11,085 and 11,106-11,113). The same suggestion was supported by witnesses representing the Stock Exchange Clerks', Baltic Corn Exchange and Lloyds' Health Insurance Societies (Q. 8535-8552), and also by Sir Walter Kinnear (Q.23,397, 23,399 and 23,407-23,427). We think that in these exceptional cases such special extension might reasonably be made as regards title to participate in additional benefits in the form of treatment. We therefore recommend that provision should be made to the effect that where the valuer certifies that a substantial part of the surplus of a Society has accrued in respect of members who have ceased to be insured as employed contributors by reason of passing over the income limit, or are likely so to cease in the near future, the scheme of additional benefits may, subject to the approval of the Minister, provide for an extension of the period during which additional benefits, other than cash benefits, may be provided to persons who are, or within a period provided by the scheme have been, members of the Society.

SECTION F.—EXTENSION OR ALTERATION OF THE LIST OF ADDITIONAL BENEFITS.

591. A list of the additional benefits, one or more of which may be adopted by a Society in the enjoyment of a disposable surplus on valuation, is contained in the Third Schedule to the Act and in the Regulations made under paragraph 14 of that Schedule. The list comprises, in all, no fewer than 19 different benefits, and we have had to consider whether additions to the list are desirable, or whether, on the other hand, any of the items included in the present list are for any reason unsuitable or redundant, and might, therefore, with advantage be deleted. On this subject we have had some interesting evidence from the Ministry of Health (see App. I, B, 201-219, and *Kinnear*, Q. 23,687-23,718). We have already referred in Chapter V to some of the more important of the present additional benefits and have indicated to what extent they have been adopted by Societies. We will now deal with some of the benefits included in the list which have been adopted by very few Societies or have not been put into operation at all.

Proposed Removal from Present List.

592. No. 1 on the list of additional benefits is "medical treatment and attendance for any person dependent upon the labour of a member." On this, Sir Walter Kinnear said, "As far as England is concerned, this benefit has never been adopted by any Society, and the provision is really one appropriate for consideration in connexion with the general scope of medical benefit. It is scarcely suitable as an additional benefit. It is of much greater importance than the question of a mere additional benefit, and its cost would be much greater than could possibly be given, as far as I can conceive, by any individual Society as an additional benefit. I therefore suggest that that additional benefit should be eliminated" (Q. 23,687). We agree that an extension of the scope of medical benefit of the kind contemplated should not be made by way of an additional benefit out of the surplus funds of certain Societies, and we would point out, moreover, that, in accordance with Section 75 (5) of the Act, this particular benefit, if adopted by any Society, would have to be administered, not by the Society itself, but by the Insurance Committee or other body responsible for the administration of medical benefit. On the ground of its impracticability under present conditions, we therefore recommend that it should be removed from the list of additional benefits.

593. No. 3 on the list is "an increase of sickness benefit and disablement benefit in the case either of all members of the Society, or of such of them as have any children or any specified number of children, wholly or in part dependent upon

them." This benefit really falls into two parts: (1) payment of increased benefit to all members, and (2) payment of increased benefit to members with dependent children. The former of these is now a feature of the additional benefit schemes of nearly all Societies, and is working well. As regards (2), the benefit is open to criticism on the ground that it makes no provision for the payment of the additional benefit in respect of a dependent wife. We are also advised (*Kinnear*, Q. 23,689) that actuarial calculations involving an amount of work wholly disproportionate to the purpose to be served would be necessary in the case of each Society proposing to adopt the benefit. We think that the question of allowances of this nature is more appropriate for consideration in connexion with the payment of increased sickness or disablement benefit to all insured persons with dependants, a subject with which we have dealt in Chapter XI of our Report. We therefore recommend that additional benefit No. 3 should be restricted to " an increase of sickness benefit and disablement benefit."

594. Additional benefit No. 4 is " the payment of sickness benefit from the first, second or third day of incapacity." We can understand a Society desiring to pay sickness benefit from the commencement of illness (and not a few Societies have, in fact, adopted this as an additional benefit for their members) or, on the other hand, being satisfied with the normal provision of the Act, under which benefit is paid only from the fourth day of incapacity; but it appears to us to be an altogether unnecessary refinement to contemplate the possibility of any arrangements intermediate between these two courses. Furthermore, the actuarial calculation of the estimated cost of paying sickness benefit from the second or third day of incapacity would be a heavy and expensive task, compensated by no corresponding advantage. We therefore recommend that the words " second or third " should be deleted from the definition of this benefit.

595. Additional benefit No. 5 is " the payment of a disablement allowance to members though not totally incapable of work." This benefit has not been adopted by any Society, and would be extremely difficult to administer satisfactorily. Without a degree of supervision which in most Societies would be quite impossible, it would be likely to lead to serious abuse. We therefore recommend that this benefit should be removed from the list.

596. Additional benefits Nos. 9 and 10 are the payment of pensions or superannuation allowances or of contributions to superannuation funds. The first of these benefits appears to us to be open to serious objection, on the ground that its enjoyment would necessarily be restricted to a small minority of the members of a Society at the expense of the general body of members. The second of these benefits—payment of contribu-

tions to superannuation funds in which the members are interested—is theoretically attractive, but is believed to be unworkable. The payments are to be subject to the prescribed conditions, and the regulations which have been made show the character of the questions in which the administering Departments would be involved, if this additional benefit were put into practice. These questions extend to the constitution of the superannuation fund, the character of the benefits provided out of it, the manner in which its moneys are invested, and its financial position as shown by its periodical valuations. As the point at issue is the payment of money which has arisen out of contributions compulsorily levied under an Act of Parliament to a fund established on an altogether different basis, it is inevitable that the regulations should provide, as they do, for the intervention of the Joint Committee in the control of the fund to an extent which, if intervention were conceded at all, could scarcely be tolerated by the management of a private and self-governing institution. There appears to be no demand for this form of additional benefit, and if a demand arose we are satisfied that the conditions prescribed by the regulations are, and must be, such that the proposal would not be pursued. We anticipate, therefore, that no use will be made of additional benefit No. 10. At the same time it must not be overlooked that the need for provision of this kind has been much lessened by the introduction of the Contributory Old Age Pensions Scheme. We recommend therefore, that additional benefits Nos. 9 and 10 should be removed from the list.

597. Additional benefit No. 11 is "payments to members who are in want or distress, including the remission of arrears whenever the arrears may have become due." The first part of this benefit, viz., payments to members in want or distress, has evidently met a need and has been adopted by many Societies, but the latter part which, it is to be noted, is restricted in its operation to members in "want or distress," a qualification which is somewhat difficult to apply, has now been rendered unnecessary by reason of the inclusion in the Regulations, under paragraph 14 of the Schedule, of a new additional benefit (No. 19), viz., "the payment in part of any sickness and disablement benefits to which a member, who is an employed contributor, would otherwise have been disentitled owing to arrears due to inability to obtain employment, and the payment of any maternity benefit to which, for the like reason, he would otherwise have been disentitled." We recommend, therefore, that additional benefit No. 11 should be restricted to "payments to members in want or distress."

598. We would also point out that the new additional benefit No. 19 would itself become superfluous if effect were given to our recommendation in paragraph 655, that there should be no

penalty in respect of arrears due to genuine inability to obtain employment.

Proposed Additions to Present List.

599. Coming now to the question of additions to be made to the present list, we have been informed by several witnesses that there is a pressing demand for the inclusion of payments for massage and electrical treatment as an additional benefit, and we have received evidence which convinces us that the provision of this benefit would materially assist in the promotion of earlier recovery in the case of persons suffering from certain types of incapacity. We would refer particularly to the evidence given before us by Dr. Smith Whitaker (Q. 23,973), and that given on behalf of the Chartered Society of Massage and Medical Gymnastics (App. LXVII; Q. 18,437-18,518). We recommend, therefore, that this benefit should be added to the list.

600 Finally, we think it desirable that the whole of the permissible additional benefits, as amended in accordance with our suggestions above, and including those at present prescribed by Regulation, should be included in the Act itself.

SECTION G.—LIMITATION ON INCREASES IN CASH BENEFITS.

601. It was suggested to us by several witnesses, most of whom appeared on behalf of Friendly Societies, that a limit should be placed by Statute upon the amount of the cash increases which an Approved Society should be allowed to provide under a scheme of additional benefits. Thus, the Hearts of Oak Benefit Society (App. IV, 144-157; Q. 3313-3331, 3349-3361, 3367) emphasised the greater relative importance to public health of additional benefits in the nature of treatment, and suggested that no Society should be allowed to apply more than 50 per cent. of a disposable surplus to increases of the normal rates of cash benefits. They are also of the opinion that "the insured population as a whole do not fully realise or appreciate the granting of additional cash benefits," and they add that "we have reason to believe that whether an insured person receives the statutory benefit of 15*s*., or the sum of, say, 18*s*. (including additional benefit of 3*s*.), the recipient is of the opinion that he is only receiving the normal benefit of the Act, and not any additional benefit for which he has not been called upon to pay a corresponding additional contribution." The Ancient Order of Foresters (App. V, 50-53; Q. 4153-4156, 4265-4266, 4271-4273, 4310-4316) also refer to the importance of treatment benefits from the preventive standpoint, and suggest that a reasonable proportion of surplus should be devoted to such benefits by each Society, and that a definite limit should be imposed on the extent to which additional cash benefits may be granted. They also express the view that any considerable

increase in the normal rates of sickness and disablement benefits would approach the borderline of over-insurance. The National Conference of Industrial Assurance Approved Societies (App. VI, 20; Q 5235, 5245-5269, 5424-5427) suggest that increases to the normal rate of sickness benefit should be restricted to 5*s*., and that not more than two-thirds of the surplus of any Society should be applied to such benefits. The witnesses also referred to the relatively greater beneficial effects of treatment benefits, and expressed the opinion that sickness benefit cannot be administered successfully without certain additional benefits in the nature of treatment. The Manchester Unity of Oddfellows (App. VII, 46-49; Q. 5580-5610, 5923, 5952-5956) urge a statutory limitation of increases in the rates of cash benefits, and consider that excessive cash payments have a tendency to destroy personal thrift. They also consider that treatment benefits are much more important from the standpoint of public health. The Independent Order of Rechabites (App. VIII, 31; Q. 6108) suggest a limit of 5*s*. in the rate of increase of sickness benefit on the ground of the greater value of treatment benefits. The Rational Association Friendly Society (App. IX, 32) state that excessive cash benefits tend to over-insurance and malingering, and on this ground suggest a statutory limitation of additional cash benefits. The Joint Committee of Approved Societies (App. XIV, 6; Q. 8202, 8211-8212) suggest a maximum rate of sickness benefit of 18*s*., in the hope that the large surpluses disclosed on valuation will thus lead to a reduction in the contribution. The Group of Catholic Approved Societies (App. XVII, 2-3; Q. 8590-8591, 8611-8625, 8645-8646) are in favour of the complete elimination of additional cash benefits, while the National Conference of Friendly Societies (App. XXVI, 14; Q. 10,650-10,660, 10,706-10,732), the Order of the Sons of Temperance (App. LXXXIX, 63-64; Q. 21,429-21,430), and the Edinburgh and Leith Friendly Societies' Council (App. LXXXI, 3; Q. 20,673-20,679) support the view that a limit of 5*s*. should be placed upon the rate of increase of sickness benefit, having in view the importance of encouraging voluntary thrift and the more beneficial effects of treatment benefits on public health. The Loyal Order of Ancient Shepherds (App. XLIV, 20) and the Standing Committee of Scottish Insured Women (App. XLVI, 5) make similar recommendations. The National Federation of Employees' Approved Societies (Q. 13,390) oppose any statutory limitation of additional cash benefits, and think that Societies should be given full discretion in disposing of their own surpluses. In conclusion we quote the following from the evidence given before us by Sir Walter Kinnear on this subject:—"The view of the Department is that it is not desirable to place a statutory limit to the possible increase of standard rates of benefit. While most Societies limit themselves to 5*s*. increase in sickness benefit, there are some Societies for which as much

as 7*s*. 6*d*. has been thought reasonable. A statutory limit would have to be above 5*s*., and would tend to be regarded as normal. The problem is to get Societies to adopt a reasonable balance between the amounts allocated to cash increases and to treatment benefits, respectively. I think that the powers of the Minister, in regard to approval of schemes of additional benefits, are sufficient to enable a check to be applied in practice on the extent of increases in cash benefits." (Q. 23,458.)

602. While it will be seen from the quotations given above that there is a considerable volume of evidence from representatives of Friendly Societies in favour of imposing a statutory limit on the amount by which cash benefits might be increased by way of additional benefit, we feel that regard must be had to the considerations which influence the Societies in this point of view. It was evident to us, and was, indeed, frankly admitted by some witnesses, that this suggested restriction was largely, if not entirely, advanced in the interests of the voluntary side of the Societies concerned, and was based on the feeling that the larger the amount of benefit obtainable under National Health Insurance, the less scope would there be for supplementing that insurance by voluntary insurance through the private sides of Friendly Societies. We recognise the force of this argument, and we have no desire to depreciate or to place any unnecessary restriction upon the great work which voluntary Friendly Societies have done and are still doing in the encouragement of thrift. We cannot, however, overlook the fact that these Societies include only a fraction of the whole insured population and that, particularly at more advanced ages, it is not possible, except by payment of an almost prohibitive rate of contribution, for an insured person, who is not already a member of a Friendly Society, to make voluntarily such provision as he may desire for supplementing the benefit obtainable under the State insurance.

603. We are informed that very few Societies provide for an increase of more than 5*s*. in the rate of sickness benefit (with proportionate increases of the other cash benefits) and that there is, moreover, a growing tendency on the part of Societies, in framing schemes of additional benefits, to allocate sums to benefits in the nature of treatment rather than to provide large cash increases.

604. While we do not favour any arbitrary restriction of the right of Societies to dispose of their surplus funds in accordance with the wishes of their members, we think that Societies, in formulating their schemes of additional benefits, should properly have regard, on the one hand, to the danger of over-insurance, and, on the other, to the disparity between the rates of sickness benefit and unemployment benefit. We are informed that the practice of the Department in cases where a Society proposes

to provide for an increase of sickness benefit in excess of 5*s* a week is to impress upon the Society the importance of treatment benefits and to induce it to allocate a reasonable proportion of the surplus to those benefits. We consider that this practice should be continued.

605. Beyond this we do not consider it desirable to lay down any fixed statutory limit to the amount which a Society may devote out of its surplus to the provision of cash increases, and we are of opinion that the question of the disposal of a surplus should be determined in accordance with the wishes of the members, subject to a reasonable control by the Department. We do not therefore recommend any change in the present position in this matter.

SECTION H.—MISCELLANEOUS QUESTIONS AFFECTING APPROVED SOCIETIES.

International Societies with few members in a particular National Area.

606. The Act does not lay down as a condition of continued approval for any national area (England, Scotland, Northern Ireland or Wales) any minimum limit as to the number of members of an international Society resident in that area. We are informed that cases have arisen in which such Societies have retained approval in respect of one or more national areas other than that in which the head office of the Society is situated although the membership in such areas may be negligible compared with the total membership of the Society. Notwithstanding its small membership in one or other of the national areas, the Society is required in such cases to keep separate accounts in respect of its business in each country and to draw its funds from the several National Health Insurance Funds for the various countries. It has been suggested to us (*Kinnear*, Q. 23,652-23,656) that, in order to simplify administration in such cases the Minister or the National Health Insurance Joint Committee should be empowered to withdraw approval in respect of any country in which an international Society has a very small membership. The effect of this would be that the Society would lose the right to accept as new members persons resident in the country in question, a right, it may be observed, which they cannot have energetically exercised in the past.

We accept the view that in the interests of administrative efficiency it is desirable to make provision to this effect. We accordingly recommend that Section 30 (2) of the Act should be amended so as to provide that where the number of members of an international Society who are resident in any country, other than that in which the head office of the Society is situated, is less than a specified small percentage of the total membership, and is not more than a certain number, approval may be withdrawn

in respect of that country, and that the members who are resident therein be deemed to be resident in the country in which the head office of the Society is situated.

Amendment of Constitution of Societies with Branches.

607. We were informed (*Ministry of Health*, App. I, B, 76-77; *Manchester Unity of Oddfellows*, Q. 5702-5704; *Loyal Order of Ancient Shepherds*, Q. 14,062-14,067; *Grand United Order of Oddfellows*, App. XCV, 1) that several Approved Societies which administer the Act through the medium of Branches had found it desirable to amend their constitution by the grouping of Branches either completely, thus converting the Society into a centralised Society, or partially, by merging the separate Branches in the different geographical areas into larger units (generally known as districts) for the purpose of the administration of National Health Insurance. As a consequence of changes of this nature, the total number of Branches administering the Scheme as separate financial units has fallen from about 14,000 in 1912 to less than half that number. It is not, however, a simple matter, under the Act as it stands, for changes of this kind to be effected since any single Branch has absolute autonomy and can decline to fall in with any proposed reconstitution of the Society, however strong may be the desire throughout the Society as a whole to effect that reconstitution. It has been suggested to us that some means should be provided by which the decision of the Society in cases of this kind should be made binding on all its Branches.

608. We have no desire to impair unnecessarily the autonomy which Branches at present enjoy, but we feel that some such provision is desirable (with proper safeguards) to meet the case where the general desire of a Society may be frustrated by an obstructive and insignificant minority.

609. We observe, moreover, that there is already provision in Section 40 (1) (*c*) of the Act for the converse operation—namely, the transformation of a centralised Society into a Society with Branches. We accordingly recommend that Section 40 of the Act should be amended so as to enable a Society with Branches, subject to the consent of the Minister and to compliance with such conditions as may be prescribed, to centralise either completely, or in geographical areas if the Society in a general meeting by a large majority (e.g., four-fifths) representative of its insured persons resolves to do so.

Investment of Societies' Funds.

610. The Act provides that, of the moneys belonging to Societies which are available for investment, one-half is to be retained to the credit of the Society in the National Health

Insurance Fund Investment Account, and the other half may be dealt with at the option of the Society in one of the three following ways :—

(1) It may be left in the National Health Insurance Fund Investment Account; or

(2) it may be paid over to the Society for investment by the trustees of the Society in trustee securities; or

(3) it may be invested by the Minister on behalf of the Society in such securities as the Society may select.

611. The moneys in the Investment Account are invested by the National Debt Commissioners in securities in which Savings Bank Funds may be invested and the interest is paid into the Income Account kept by the National Debt Commissioners From time to time the National Health Insurance Joint Committee, with the approval of the Treasury, after a survey of the position determine the rate of interest to be credited to Societies in respect of their credits in the Investment Account. The prescribed rate was $3\frac{1}{4}$ per cent. up to December, 1917, 4 per cent. from that date until December, 1922, and has been $4\frac{1}{2}$ per cent. since the latter date. Any balance of interest earned over and above that credited to Societies at the prescribed rate, and any capital accretions on changes of investment go to provide a reserve for the stabilisation of the rate of interest and to protect the fund against depreciation.

612. So far as concerns the moiety of the funds available for investment which is transferable to the Societies, there is no corresponding arrangement for equalising the rates of interest, either as between Societies or as between one period and another. Within the range of securities on the trustee list, each Society makes its own investments and carries the whole of the interest receipts of each year to its Benefit Fund. Profits or losses, resulting from the sale of securities, are also carried to revenue in the year in which they arise. In the case of Branch Societies which make common investments for the Branches, the effect is the same, though the machinery is slightly different.

613. There is little difference between the ultimate results of the two methods of investment. Theoretically, the Societies might be expected to realise a somewhat higher rate of interest, owing to the wider range of securities which is open to them. Practically, the results are much the same, since the Societies have, to a very large extent, preferred to invest in Government securities of the same type as the National Debt Commissioners have selected. Differences, attributable to accounting policy, i.e., to the creation of a reserve for equalising purposes in the case of one-half only of the funds available for investment, may be disregarded in this connexion. Any apparent inferiority in the results of official investment due to this cause should be

looked upon as a merely temporary feature for which compensation will be provided at a later period. These facts must be kept in view in considering the evidence directed to the question whether any change is desirable. The evidence we have received shows that the Societies are, as a rule, more fully appreciative of the results of their own investment operations than of those of the corresponding official activities as expressed by the credits of interest at the "prescribed rate." Nevertheless, there is no general desire for change.

614. The Ancient Order of Foresters (Q. 4376-4379) have no objection to the present arrangements, though in their own investments they state that they earn 4·9 per cent. interest, with large capital appreciation. The National Amalgamated Approved Society (App. XXV, 33-34) propose no change, though they have realised similar results. The Lancashire and Cheshire Miners' Permanent Approved Society (App. XI, 31-34) suggest that wider powers of investment should be given to Societies. The Hearts of Oak Benefit Society have recommended (App. IV, 307-319; Q. 3667-3708) that Societies should be empowered to invest the whole of the moneys available for investment on the ground that the Society would gain by capital appreciation. On examination, however (Q. 7394-7449), it appeared that this Society had not improved its interest income by the rather considerable series of investment changes on which it had embarked, and had, therefore, added nothing to its real assets. It appeared to us that in these circumstances the capital appreciation in which the transactions resulted represented no such tangible advantage as to commend to us the proposition that Societies should be given control over an extended proportion of investable funds.

615. We have come, therefore, to the conclusion that no change should be made in the present arrangement under which one-half of the funds available for investment is carried to the Investment Account and dealt with in bulk by the National Debt Commissioners, the other half being made available as regards each Society, for investment by the Society itself, or at its direction, in trustee securities. This plan was adopted in 1911 as a modification of that originally proposed by the Bill, under which the whole of the accruing funds would have been invested by the National Debt Commissioners; it was the subject, therefore, of an important amendment to the Bill, and one which must have been fully considered at the time. It cannot be said to have operated to the disadvantage of the insured persons. So far, indeed, from this having been the case, it has provided opportunities of comparing alternative policies in regard to the treatment of interest income which may lead to very valuable conclusions if the experiment is allowed to continue for a sufficiently prolonged period to enable definite results to

emerge. It may be laid down as an axiom that changes in a system which at its inception was submitted to the closest scrutiny in every aspect are only to be recommended when a good case for them has been made out as the result of subsequent experience. In the present instance we must hold that no such case has been established.

616. We see no adequate reason for the adoption of the suggestion that wider powers of investment should be given to Societies, having regard to the ample range of securities available for trustee investments. Here again we must point out that the present regulations are the result of a careful study of the whole question, in this case by a body of financial experts who composed the Investments Advisory Committee set up in 1913 and whose report emphasised the sufficiency of the scope of the list of trustee securities for the investments of Approved Societies.

617. We recommend that no change be made in the provisions of Sections 70 and 71 of the 1924 Act relating to societies' powers of investment of their accumulated funds.

Allowances to Approved Societies for Expenditure on Administration.

618. We are informed that the whole question of the sums to be made available to Approved Societies for the purposes of administration was the subject of close inquiry by a Departmental Committee in 1921, and we are satisfied that the evidence we have heard on the subject is not such as to warrant any reconsideration of the matter. Apart from the general consideration to which we refer in paragraph 229 above, we are informed that the present rate of allowance is sufficient for all types of societies, and the evidence which we have received from the Approved Societies themselves would generally seem to confirm this view. The Ancient Order of Foresters (Q. 3945) think that the present rate of allowance is "sufficient without being generous." The Manchester Unity of Oddfellows (Q. 5474) think the allowance is adequate. The National Conference of Friendly Societies (Q. 10,646-10,648) "are not satisfied, but make the best of it." The Association of Approved Societies, however, express the opinion (App. XLV., 27-32; Q. 14,392-14,411) that "the amount allowed to Approved Societies for administration purposes is too low, and militates against efficiency without voluntary service," and advocate an increase to cover the reasonable expenditure of each type of Society. The Order of the Sons of Temperance (App. LXXXIX, 22-25; Q. 21,405-21,413) informed us that "when the number of members is 15,000 and over the allowance meets the requirements, and when the smaller units do not require office accommodation or permanent staff, there again the

administration allowance has been found to be sufficient." They submit, however, that the allowance is insufficient where the membership lies between 5,000 and 10,000.

619. It has been suggested by some witnesses that a variable rate of allowance should be instituted according to the size and type of Societies. For instance, the National Association of Trade Union Approved Societies (App. XCII, 144-148; Q. 22,074-22,075) point out that the rate of administration expenditure varies according to the type and size of Society. They suggest that the Ministry should be empowered to vary the amount in the case of Societies with a membership between a given minimum and maximum. They also make the specific suggestion that the allowance should be increased to 4*s.* 10*d.* per member per annum in the case of Societies with less than 50,000 members, and that an additional twopence per member should be allowed in the case of women. The Hearts of Oak Benefit Society (Q. 2972-2974) and the Order of the Sons of Temperance (Q. 21,590) also think that the rate of allowance should be varied according to the type and size of Society. We are not convinced that there is much substance in this claim. On the contrary, we see grave objections to the adoption of a differential rate of administration allowance as between different types of Societies. The adoption of such a device as we have indicated might with some justice be represented as, and it might in fact easily become a contrivance for subsidising the administration of certain forms of organisation at the cost of their own members' benefits. Health Insurance exists to promote the advantage of the insured, in whose interests it is essential that there should be throughout the whole administration of the Act a spirit of wise economy. No Society and no type of Society can claim a prescriptive right to a guaranteed existence, quite apart from any question of the cost of its administration. While inevitably in the multitude of Societies there will be differences in the cost of administration, it is, we consider, a sound principle that no Society in respect of its administration should require a sum materially in excess of that which the great bulk of other Societies find sufficient. Economy is, after all, one essential constituent of efficiency, and any type of Society which is less markedly economical than other Societies, is ultimately to be condemned as inefficient. Apart from these general considerations we do not consider that differential rates for administration allowance would in any case be defensible in a scheme subject to statutory provisions under which uniform contributions are charged; moreover, we are advised that difficulties would arise in connexion with the valuation of Societies if effect were to be given to such a suggestion. We, therefore, recommend that no change in the existing provision should be made except in respect of the matter dealt with in paragraph 242 of our Report.

Contract Administration Payments.

620. Our attention has been directed to an arrangement which exists in certain Societies whereby out of the amount available to the Society for purposes of administration a lump-sum payment is made to the parent body with which the Society is associated, and in return for that payment the parent body carries out the administration of National Health Insurance on behalf of the Society. We are informed that the arrangement is in every case expressly authorised by the rules of the Society, and that the terms of the agreement and the rates of payment are subject to annual review and are approved by the National Health Insurance Joint Committee. Although the number of Societies which have made arrangements of this kind is small, they have an aggregate membership of about 6½ millions, or nearly half the total insured population. We may quote from the evidence of Sir Walter Kinnear on the subject :—

> "We have a limited number of cases, possibly not more than a dozen in number, where a certain proportion, not the whole, of the administration allowance is paid over with the sanction of the Minister to what I might call the independent side of the organisation. As a rule we insist that the cost of certain services which are peculiar to National Health Insurance, such as medical referees, sick visitors, and matters of that kind must be paid for and retained on the Approved Society side of the organisation. But certain Societies have represented to us that they have common organisation and common staffing in the offices, and they said it would be a businesslike arrangement for us to allow a proportion of the administration allowance to be handed over to the parent body and the latter would contract with the Approved Society to give the services of their whole organisation to the benefit of the Approved Society for that sum, apart from any special services which are peculiar and can be rendered only for the purpose of National Health Insurance. That is a system which has been in force for a good many years, and I am not inclined to think it is abused. It is true that at headquarters we have no means by which we can analyse how the amount is spent, once having fixed upon a lump sum. We have simply to look at the cost of that Society as compared with the cost of other Societies, and endeavour as best we can to decide whether that lump sum which is agreed upon is a fair and equitable amount. I do not think the system has been abused; I do not think that the Society is placed at any serious disadvantage by the arrangements; but, of course, it is open to the criticism that there is a very considerable expenditure over which we have no supervision or no auditorial rights." (Q. 23,527.)

621. We recognise that an arrangement of this kind may have some advantages from the business point of view, and we

do not suggest that it should be prohibited, provided that the interests of the insured members of the Societies are properly safeguarded. The amounts of the payments made by some Societies under arrangements of the kind in question are very considerable. In the case of the Prudential Approved Societies, sums totalling nearly £700,000 a year are paid out of the State Insurance funds to the Prudential Assurance Company, and these payments appear as single items in the accounts of the Approved Societies as submitted to the Treasury Auditor and to the insured members, no details being available of the manner in which the money is applied by the Company. We feel, therefore, that a serious responsibility rests upon the Central Departments to scrutinise closely the terms and conditions of any proposed arrangement of this kind before giving their approval. The National Amalgamated Approved Society informed us (Q. 4812-4826) that the Companies with which the Society contracts make no profit out of the arrangement, while the National Sailors' and Firemen's Union (App. XLIII, 26; Q. 13,990. 14,006-14,008) stated that the Trade Union actually lost on the arrangement. We should have expected that very large Societies having at their disposal for the purposes of the administration of National Health Insurance all the machinery of a huge business undertaking, would have been able to carry out their National Insurance administration at an appreciably lower cost per head of membership than Approved Societies in general, and we are surprised to find that this is not in fact the case. We questioned witnesses representing the Prudential Approved Societies on the subject, and it appeared from their evidence (Q. 9750-9765) that, although a considerable reduction had recently been effected in the overhead charges of the parent Company as a result of certain measures of reorganisation, that reduction had not been reflected in the amount paid to the Company by the Approved Societies. We feel that it is only reasonable that the insured members of the Societies should receive some compensating advantage under arrangements of this character in return for their surrender of their ordinary right of scrutinising and criticising the detailed expenditure of the Society's funds for purposes of administration, and we think that before giving their approval to such arrangements, the Central Departments should take all possible steps to satisfy themselves that this will be secured.

622. Our attention was also drawn (*Kinnear*, Q. 23,542) to another type of case, in which an Approved Society pass over to the secretary the bulk of the money available for purposes of administration, and the secretary in return undertakes to contract for the whole administrative work of the Society, the persons by whom the work is undertaken being appointed and paid by himself and not being responsible to the Committee of Management or the

members of the Society. We think that arrangements of this kind are open to serious objection and are not in the interests of good administration. We consider that the Central Departments should have power to bring any such arrangements to an end by requiring the amendment of any rule which purports to authorise them.

SECTION K—OTHER MISCELLANEOUS QUESTIONS.

Workmen's Compensation.

623. Inasmuch as the Workmen's Compensation Act had already made provision for payments being made to insured persons in respect of certain types of incapacity (those, namely, due to accidents arising out of and in the course of their employment), it was possible, and indeed desirable, in framing the Insurance Act to regard such illnesses as being already covered and accordingly to disentitle an insured person from benefits under the Act in respect of incapacity already compensated under other statutory provision. Moreover, it was clearly expedient to make provision to secure as far as possible that claims which were met by the employers in the form of payment of compensation should not be the subject also of demands on the Health Insurance Funds to which employers contribute.

624. The statutory provisions governing the relations between workmen's compensation and payment of benefit under the Health Insurance Scheme are contained in Section 16 of the Act and are briefly summarised in the following paragraphs.

625. An insured person is not entitled to sickness or disablement benefit in respect of any incapacity for which he is entitled, under the Workmen's Compensation Act, to receive compensation of a value equal to or greater than that of the benefit. An employer is required to notify to the Minister, or to the Approved Society concerned, any agreement for the payment of compensation of less than 15*s*. a week, or for the redemption of weekly payments by a lump sum. An Approved Society is entitled to help its members to obtain the compensation to which they appear to be entitled, and is authorised to make advances of sickness or disablement benefit pending the settlement of the claim for compensation and to recover any amounts so advanced from the compensation awarded.

626. The evidence which we have receives satisfies us that these provisions are working satisfactorily, and that it is only in a few minor details that any amendment is required. It was suggested to us by a number of witnesses that workmen's compensation should be merged in the Scheme of National Health

Insurance. We examined Sir Walter Kinnear on this proposal, and we give the following extract from his reply : —

> " . . . The Department considers that it would not be practicable or desirable to merge the Workmen's Compensation Scheme in the Health Insurance Scheme. . . . The risks covered by the Workmen's Compensation Act vary very greatly in various trades. These risks entail considerable variation in the rates of premium as between different occupations and a frequent revision of rates according to claim experience. I suggest that such a system could not be worked in conjunction with a general scheme of insurance based on flat contributions. If a flat rate of contribution were charged, it is suggested that such a system would be inequitable to the trades carrying the lighter risks, and would in any case remove from employers the incentive which at present exists to reduce the risk of accidents and thus secure a reduction in their premiums. In any case, the Department considers that it would not be practicable for Approved Societies organised on their present lines to administer workmen's compensation insurance. The workers contribute a substantial proportion of the contributions to the funds of the Approved Societies, and the Act provides for those Societies being under the absolute control of their members. If on the valuation of a Society's funds a deficiency is found, the members may be rendered liable to an increase in their contributions or a reduction in their benefits. In workmen's compensation insurance the whole of the premiums are contributed by the employers, who alone would be affected by any excess of claims and expenses over income. The working of such a scheme could not be entrusted to Societies controlled solely by the workers. Moreover, the financial liabilities of workmen's compensation insurance are more onerous than could with prudence be undertaken by many of the 9,000 Approved Societies and Branches throughout the country, and if these liabilities were pooled in a central fund, I submit to the Commission that the Societies could not retain that independence in government and administration which characterises their operations at the present time." (Q. 23,461.)

627. We consider that the arguments advanced by Sir Walter Kinnear are conclusive on this subject, and we cannot recommend that the Health Insurance Scheme should be widened to cover the liability now provided under the Workmen's Compensation Acts.

628. The National Association of Trade Union Approved Societies (App. XCII, 117-120) called our attention to cases in which insured persons who are incapacitated by accident

for which compensation is payable are unable to obtain compensation by reason of the employer or other person responsible being unable to meet his liability, and are at the same time unable, by reason of the disentitling provisions of the National Health Insurance Act, to obtain any benefit from their Approved Societies. The Association suggested that in order to meet the very unsatisfactory position which thus arises, the Act should provide that "unless an insured person unreasonably neglects or refuses to enforce his claim, benefit should be payable if compensation is not recovered."

629. We have no reason to think that cases of this kind are numerous as they are confined to those in which an insured person has established his title to compensation prior to the employer becoming insolvent. Moreover, even in such cases, the employed person's claim to compensation ranks preferentially on the assets of the employer. At the same time, though the cases may be few they involve real hardship, and in our opinion the present position cannot be justified. We, therefore, recommend that provision should be made whereby in any case where an award of compensation or damages has been made in favour of an insured person, and the payment cannot be recovered by reason of the insolvency of the employer or other person liable, sickness or disablement benefit should then become payable.

630. The only other matter in connexion with workmen's compensation on which we desire to make a recommendation relates to the notification of agreements. On this point we may quote from a question addressed to Sir Walter Kinnear and his reply :

"Are you satisfied with the present arrangements under which Societies are notified of cases in which their members become entitled to claim compensation under the Workmen's Compensation Act?—Under the Workmen's Compensation Act, 1923, and the Rules of Court made under that Act, Approved Societies are now recognised as interested parties in any agreements for the payment of a lump sum, and arrangements have been made for the notification of such agreements by the Registrars of the County Courts to the Approved Society concerned. These arrangements are working well and should enable a Society to receive prompt information of the cases about which it is important that it should know. There is still in force Section 16 (1) (*c*) of the Act, which requires the employer or insurance company—in fact it is really the insurance company—to forward a notification to the Ministry or Society where there is an agreement for compensation at less than 15*s*. a week, or for redemption of a weekly payment by a lump sum. This provision has never been of much use, as out of thousands of cases notified it has not

been possible to get the information to the Society in more than a minute fraction of cases. As the cases of lump sum payments are now covered otherwise, as the result of the passing of the Workmen's Compensation Act, 1923, and the cases of weekly payments at less than 15s. a week are relatively unimportant, I suggest to the Commission that Section 16 (1) (*c*) of the Act might now be repealed." (Q. 23,462.)

631. We concur in the suggestion made to us on this point and recommend accordingly that Section 16 (1) (*c*) of the Act should be repealed.

Inquiries into Excessive Sickness.

632. When the Insurance Act was originally passed few sections attracted more attention than that which was designed to establish machinery whereby financial liability might be fixed on a local authority or an employer, held to have been guilty of default leading to unsatisfactory health conditions and consequent excessive payments of sickness or disablement benefit. This was regarded as establishing a hopeful new principle whereby the consequences of neglect might be brought home to the negligent with beneficial results to the public health at large.

633. Section 107 of the present Act lays down the procedure to be followed where an Approved Society or Insurance Committee makes an allegation that excessive expenditure on sickness and disablement benefits is attributable to some default on the part of a Local Authority or an employer. The Section falls naturally into two parts. In the first place it provides machinery for instituting an investigation to determine whether the Society's allegation of unsatisfactory conditions is well founded; and secondly, it enacts that where as a result of such investigation, it is found that the unsatisfactory conditions do in fact exist and have been the cause of excessive benefit expenditure, a penalty shall be imposed on the responsible Local Authority or employer by requiring them to pay to the Society the estimated amount of the excess expenditure due to their default.

634. We have been informed in evidence (*Brock*, Q. 1470, 1491-1498) that the Section has not proved to be workable, and we understand that there are two outstanding difficulties in giving effect to its provisions:—

(1) As Approved Societies are seldom organised on a geographical basis, it is very difficult, if not impossible, to establish from their records the sickness experience among insured persons in a particular locality.

(2) Even if it were possible to establish the experience of a particular locality it would not be possible to disentangle

that proportion of the excessive sickness which could properly be attributed to any particular cause from among the many which might be operative, and so to enforce the penalty contemplated in the Section.

635. A further difficulty, we are advised, would arise in the ascertainment of the normal sickness experience of any area, and without such data it would not, of course, be possible to calculate the amount of the excess.

636. A few witnesses have given evidence before us as to the possible utility of the section in the future. Sir Wm. Glyn Jones refers (Q. 24,423) to the high intentions underlying the section, and suggests that work of the nature contemplated could usefully be undertaken by the local authorities. He also suggests that the cost of the work should be borne by rates and taxes, and that the Insurance medical records should be used for this purpose. The National Association of Trade Union Approved Societies (App. XCII, 122; Q. 22,056) suggest that the section should be retained as it may prove to be more practicable as the Scheme of National Health Insurance develops. The British Medical Association suggest (App. XLVII, 54; Q. 15,313, 15,317-15,323) that Approved Societies should be required to keep records on a territorial basis so as to assist in any investigation into prevalent illnesses in any particular area.

637. While we are convinced that the Section as it stands is incapable of effective application, we think that insurance data would undoubtedly prove of great value in connexion with any investigation into local health conditions, provided that any power to make inquiry into the causes of excessive sickness were exercised by the body responsible for the local administration of medical benefit and other health services.

638. We have accordingly come to the conclusion that the penal provisions directed against the local authority or the employer are useless as a means to further the end which the section has in view and that they should accordingly be eliminated. But we think that the bodies responsible for the local administration of Medical Benefit to insured persons should be given power to institute inquiry into cases of excessive sickness brought to their notice, and that for this purpose they should have access to the medical records collected under the Health Insurance Scheme.

639. In our opinion such inquiries need not necessarily be formal in character and indeed they would probably gain in fruitfulness by remaining informal. We consider that the powers suggested should merely be among the normal functions of the authority.

Medical Institutions.

640. While the Insurance Act contemplated that Medical Benefit should normally be provided by medical practitioners under contract with Insurance Committees, it provided for two possible deviations from the standard arrangements. In the first place it authorised Insurance Committees where they saw fit, to allow insured persons to make their own arrangements for receiving Medical Benefit, and where the circumstances were sufficiently exceptional to justify the adoption of this course a contribution was made towards defraying the cost of the Medical Benefit so obtained. The second exception related to medical institutions which had been providing medical attendance to the working classes in the past, and provision was made, safeguarding existing rights, whereby under certain conditions these institutions might be incorporated in the machinery for providing Medical Benefit. It is with the second of these exceptions that we are here concerned.

641. Under Section 15 (4) of the 1911 Act such systems or institutions for the provision of medical attendance and treatment, as were in existence at the date of the passing of the Act, might be approved by an Insurance Committee and the Department for the purpose of providing Medical Benefit. Insured persons who were members of these approved institutions might then receive their medical benefit through the institution, the actual cost of the treatment, or the capitation fees in respect of members so treated, whichever is the less, being paid to the institution out of insurance funds. The majority of these institutions are bodies which were formed by associations of the Friendly Societies for the purpose of providing medical attention and treatment to their members prior to the passing of the 1911 Act.

642. We are informed (*Brock and Smith Whitaker*, Q. 24,009-24,012; *British Medical Association*, Q. 15,222) that the treatment given to members of these institutions is as a rule inferior in quality to that provided under the normal panel arrangements, and we are also given to understand (*British Medical Association*, Q. 15,221; *Brock*, Q. 24,009) that administration and control by lay committees has proved in many cases to be ineffective. Any disciplinary action taken by Insurance Committees following upon complaints made by members of the Institutions cannot be brought to bear directly on the individual doctors responsible as these are the servants of the institutions. The Minister has power to withdraw approval in any case in which he is not satisfied that an institution is conducted in such a manner as to comply with the terms of service of insurance doctors, but this would not be an appropriate penalty in cases of complaint by an insured

person, and we are informed that so far there has been no case in which the penalty has been imposed.

643. After careful consideration of all the evidence before us we think that this method of providing medical attention and treatment is an anomalous feature in a scheme of which the cardinal principle is a contract between Insurance Committees on the one hand and individual independent doctors on the other, and that it introduces lay control over professional men in an undesirable form. On the other hand we consider it necessary to have regard to the recognition by Parliament of these institutions at the time when the scheme was introduced, and to the fact that there is no evidence of failure sufficient to justify a recommendation on our part that the recognition of the institutions for the purposes specified should now be withdrawn. The original Act, it will have been noted, restricted recognition to those institutions then in existence, clearly designing that this method of providing Medical Benefit should be exceptional and should be regarded as an unavoidable inheritance from the past. We do not consider either that that decision should be reversed, or that power should now be given to recognise further institutions beyond a small group of a special type, to which we refer in paragraph 648 below. On the question of the control over the salaried doctors in the institutions, we feel that that must necessarily continue to be exercised by their employers who are the committees of the institutions, though at the same time we think that no rule of an institution should purport to debar a member of the institution from carrying an appeal as to his medical treatment to the Insurance Committee in the area.

644. Our attention has been directed to the peculiar position of the medical institutions in South Wales specially set up under Section 24 (3) of the 1924 Act for the provision of medical treatment and attendance to persons who are allowed to make their own arrangements for Medical Benefit.

645. A distinction is to be drawn between those medical institutions which were in existence before the date of the passing of the original Act and which have been approved under Section 15 (4) of that Act (Section 24 (4) of the 1924 Act), and those new institutions which, although they are not entitled to recognition under Section 24 (4), are set up for the provision of medical benefit under what is known as " collective own arrangements " allowed by Insurance Committees under Section 24 (3). In these cases the Insurance Committees in effect allow insured persons to make their own arrangements to receive medical benefit through an institution which is debarred from recognition as such under the Act. With regard to the latter type of institution, the British Medical Association, in their evidence, objected to the fact that they were under lay control, and stated (Q. 15,222) that " their influence has been very detrimental indeed to the

medical service given to the public in the colliery areas of South Wales." Mr. Eynon Lewis, representing the Glamorgan Insurance Committee, admitted (Q. 13,289) that " there may be a difference in the quality of the service of a practitioner which an organisation approved under Section 24 (3) may obtain as compared with an institution approved under Section 24 (4) because of the ban of the British Medical Association."

646. After careful consideration of all the evidence we have come to the conclusion that organisations recognised under Section 24 (3) of the Act are open to objection inasmuch as their existence is, in effect, an evasion of section 24 (4) of the Act and an improper use of Section 24 (3), the real purpose of which we conceive to have been the provision for individual cases and such special types as nurses in hospitals. The concession granted by section 24 (4) was definitely limited to those institutions which were actually in existence at the date on which the original Act was passed. The recognition of new institutions specially set up for the purpose of " collective own arrangements " cannot, in our view, be regarded as consistent with the limiting provisions of Section 24 (4), which would indeed be stultified by any extension of this procedure.

647. We therefore recommend that Section 24 (3) of the Act should be amended so as to debar any Insurance Committee, or Local Authority succeeding to its powers, from sanctioning the use of any organisation for the purpose of " collective own arrangements," and to provide that the provisions of the Subsection shall not be applied otherwise than to individual insured persons. We wish, however, to make it clear that our recommendation does not apply to cases in which nurses or other resident employees of hospitals normally receive medical treatment and attendance from the medical staffs of the hospitals in accordance with the terms of their employment.

648. With regard to the existing institutions which have already received recognition under Section 24 (3) we do not suggest that such recognition should be withdrawn, but recommend that approval should be extended to them under Section 24 (4), and that such amendment of Section 24 (4) as may be necessary to enable this to be done should be effected.

Dispensing of Drugs for Insured Persons.

649. It is provided by Section 24 (5) of the Act that all medicines supplied to insured persons shall be dispensed either by, or under the direct supervision of, a registered pharmacist or by a person who for three years immediately before the passing of the 1911 Act acted as a dispenser to a duly qualified medical practitioner or a public institution.

650. It was suggested to us in evidence given on behalf of the Society of Apothecaries of London (App. LXXXVI; Q. 21,218-21,236) that the section referred to should be amended so as to provide that those persons who hold a certificate of the Society as dispenser, and who have, in addition, had three years' practical experience, should be recognised as "qualified to exercise any function required of a dispenser in institutions, hospitals, dispensaries and Poor Law infirmaries, and to contract with Insurance Committees for the payment for medicines supplied to panel patients in those institutions." The Society contend that their training and examination secure an adequate test of ability to dispense accurately and successfully. The Pharmaceutical Society of Great Britain, on the other hand, state (App. CXXVI) that in their view "any reduction in the standard of qualification required of persons undertaking dispensing for insured persons would be a retrograde step," and refer to the fact that a similar claim made by the Society of Apothecaries in 1913 was exhaustively considered by a Departmental Committee and was rejected.

651. We examined the official witnesses on the subject (Q. 24,005-24,007), and quote from a reply given by Mr. Brock :—

> "We have to distinguish between the right to dispense in the literal sense of the term and the right to enter into arrangements with Insurance Committees for the supply of drugs to insured persons. In our view it would not be desirable to relax the present statutory requirement prohibiting arrangements for dispensing medicines being made with persons other than qualified pharmacists, even though such medicines are not supplied in open shop. The period of training required for the certificate of the Society of Apothecaries has been raised from six to nine months, but the standard of technical training is still not high, and it would be a retrograde step to amend the Act so as to allow persons holding this qualification only to contract for the supply of medicines."

652. We have given careful consideration to this question and have come to the conclusion that it is not desirable in the interests of insured persons to lower the standard of qualification required for persons who may be allowed to dispense medicines provided under the Insurance Scheme. The evidence given before us has left no doubt in our minds that the qualification of the holders of the Apothecaries' Assistants' Certificates is inferior to that of a registered pharmacist, and we accordingly recommend that no alteration should be made in the present requirement.

Arrears of Contributions.

653. The present position governing the effect of arrears of contributions is set out at length in paragraphs 103-110 of

Section A of Appendix I, to our Minutes of Evidence and it is not, therefore, necessary to enter into any detail here on the subject. The absence of a contribution in respect of any particular week in the case of an employed contributor may be due to any of the following causes :—

(1) absence from work owing to sickness;

(2) absence from work owing to genuine inability to obtain employment;

(3) voluntary abstention from work;

(4) the taking up of some non-insurable occupation.

Arrears due to the first of these causes do not involve any penalty but in each of the other three cases, unless the arrears are redeemed by payment of the appropriate sum within the time allowed for the purpose, an insured person with arrears exceeding four during the year is subject to a penalty in the form of a reduction or suspension of the cash benefits. The title to medical benefit is not now affected by arrears so long as the insured person remains in insurance. Special temporary arrangements have been made under the Prolongation of Insurance Act and by related provision in the Arrears Regulations to mitigate the consequences of arrears in the case of insured persons who have had prolonged periods of unemployment during the present trade depression.

654. It has been represented to us in evidence that it is illogical that penalties in the form of a reduction or suspension of health insurance benefits should be imposed on insured persons who have been so unfortunate as to suffer from genuine unemployment, particularly having regard to the fact that under the Unemployment Insurance Scheme contributions are compulsorily payable against the contingency of unemployment and benefit is paid when that contingency arises. These schemes are alike authorised and enforced by the State; yet the circumstance which establishes the insured person's title to benefit under one scheme involves a penalty under the other. We are impressed by the force of these arguments, and we think that a fundamental distinction should be recognised between arrears arising from genuine inability to obtain work and those arising from voluntary abstention from work, or from employment in some non-insurable occupation. While arrears due to the last two causes must necessarily and properly involve the imposition of penalties, we do not consider that any penalty should be imposed in respect of the non-payment of a Health Insurance contribution for a week during which an insured person was genuinely seeking for work but unable to obtain it. We have received evidence from the Ministry of Labour on the subject (App. CII; Q. 23,290-23,395), and we understand that the Ministry are prepared to accept the general principle which we have set out above, but at the same time think it necessary to point out the difficulties of devising any satisfactory machinery for proving

that the absence of a contribution for a particular week was, in fact, due to inability to obtain employment.

655. We feel, however, that these difficulties to which Mr. Price, a Principal Assistant Secretary of the Ministry of Labour, alluded in his evidence should not prove insuperable and we, therefore, recommend that for the purposes of the Health Insurance Scheme, any week in respect of which an employed contributor can produce satisfactory evidence of genuine inability to obtain work should be counted as a week for which a contribution was paid. We are not in a position to make detailed recommendations as to the machinery by which evidence of genuine unemployment should be obtained. We understand, however, that the Ministry of Labour is sympathetically considering the question and that a satisfactory solution of the problems to which it gives rise may be expected to result from consultation between the two Departments, so far as concerns the large majority of persons who are insured under both the Health and Unemployment Schemes.

656. If arrears due to genuine unemployment were excused in accordance with our recommendation, it should result in great simplification in the administration of National Health Insurance and a great saving of work to Approved Societies. If the arrears involving penalties could then be limited to those due to voluntary abstention from work or engagement in some non-insurable occupation, the system of penalties for arrears might be simplified by the adoption of one scale for employed and voluntary contributors.

Payments to Charitable Institutions.

657. The original intention of Section 21 of the 1911 Act (now Section 26 of the Act of 1924) was to enable Approved Societies and Insurance Committees without any question of receiving an equivalent return to make subscriptions or donations to hospitals or charitable institutions which serve the interests of the public health.

658. We have had evidence (*Kinnear*, Q. 853; *Ministry of Health*, App. I, B, 247; *Middleton*, App. CI. 34) that the Section is now used by some Societies for the purpose of providing benefits in the nature of additional benefits to all members, whether qualified to receive additional benefits or not, by paying fairly large sums in anticipation of surpluses to institutions specially set up to receive such payments.

659. These institutions are in some cases little more than the Societies themselves under other names, and in other cases bodies set up by enterprising officials of Societies, and with very little, if any, income from any source other than payments out of the Health Insurance funds of contributing Societies. These payments are made in bulk to the Institutions, and no details are

available to the Government Auditor as to the manner in which the sums are used by the Institutions. As an illustration of the former type we may instance the United Women's Benevolent Association (see *Gordon*, App. XIII 28, 30; *United Women's Insurance Society*, App. XXIV 22-31), and of the latter type the outstanding example is the National Insurance Beneficent Society, a body from whom we received some interesting evidence (App. XVIII; Q. 8814-9208). This body carries on its work not only under Section 26 but also as an agent for Societies in administering treatment benefits under approved schemes of additional benefits, and has adopted a two-sided constitution the full purpose of which we are not altogether able to appreciate.

660. We are informed by the Ministry of Health (App. I, B, 229-252; *Kinnear*, Q. 843-857, 23,603-23,615) that in 1922 a sum of £10,000 was paid to charitable institutions by 138 centralised Societies, and that in 1923 the sum so paid was over £30,000 including a payment by one Society of over £11,500. The Ministry also informs us that the section is open to objection on the grounds (1) that it is used by some Societies to provide benefits in the nature of additional treatment benefits to members immediately on transfer from other Societies, and so encourages unfair competition; (2) that inasmuch as the contribution contains no margin for payments of this nature, the financial stability of Societies may be endangered; and (3) that it is a violation of the spirit of the provision that additional benefits shall not be distributed among members other than those entitled thereto by statute. It was therefore suggested to us that the section should be repealed and that payments to charitable institutions should not be made except out of surplus funds. The Scottish Board of Health, on the other hand, maintain (*Leishman*, Q. 24,248-24,293) that so far as Scotland is concerned the section has been cautiously and reasonably used, and suggest that it should be retained in its present form. The Ancient Order of Foresters informed us (Q. 4267) that the section was useful in the early days of the Act, but that in view of the almost universal provision of additional benefits it has outlived its usefulness. The National Association of Trade Union Approved Societies (App. XCII, 116; Q. 22,053-22,054) contend that the section permits of abuse and encourages unsound competition between Societies. They suggest that it should be amended so as to make subscriptions or donations over a certain prescribed sum per head of the membership in any year subject to the consent of the Central Departments. Mr. Middleton, giving evidence on behalf of the National Insurance Audit Department, informed us (App. CI. 33-38) that "the section, in express terms, confers absolute discretion upon the Society in the matter of amount of such subscriptions, and an auditor is therefore precluded from criticising the amount of the payments made under these powers, provided always that the payments appear to be

made in exercise of that power and do not appear to be a flagrant abuse thereof." He also states that "in view of the terms of the section, auditors have been unable to raise objection to subscriptions on the ground of absence of consideration or because an inadequate return was either contracted for or actually received for the payment."

661. Mr. Alban Gordon (App. XIII, 30; Q. 7733, 7813-7818) suggests that the section should be retained, but that in order to prevent abuse, it might be amended to provide that payments in excess of a prescribed sum per head of the membership in any year shall be subject to the consent of the Department. The United Women's Insurance Society, of which Mr. Alban Gordon is the Secretary (App. XXIV, 11-12; Q. 10,183-10,185). make a similar recommendation. This Society also inform us that during the years 1914-1924 they spent a sum of no less than £51,500 under the section. The National Federation of Rural Approved Societies (App. XXIX, 20; Q. 11,687-11,690) and the Scottish Rural Workers' Approved Society (Q. 11,781-11,788) are opposed to the repeal of the section, which they say has proved useful for providing treatment and appliances in necessitous cases. The Joint Committee of Approved Societies (App. XIV, 35, 91-108; Q. 8726-8728) also think that the section should be allowed to stand. They contend that it has not endangered the financial position of Societies and is useful for meeting cases of special need.

662. The use made of the section has undoubtedly gone far beyond the original intention of the legislature, and while we recognise the motives which originally prompted Societies to provide benefits in the manner indicated, we consider that any need for such payments has now passed, seeing that the benefits may be provided as additional benefits.

663. We consider, however, that the power vested in Societies to make small subscriptions or donations to hospitals and similar charitable institutions should be retained, but that any such payments should not be made except out of realised surpluses, and that they should be made under some degree of central control.

664. We therefore recommend that the Section should be repealed, and that provision should be made whereby a Society may, when formulating a scheme of additional benefits, allocate a specific sum out of the disposable surplus for the purpose of making payments to charitable institutions, this provision to be submitted as part of the Scheme and to be subject to the same scrutiny and control by the Central Department as are the proposals for additional benefits. We also think it desirable to define in fairly precise terms what constitutes a charitable institution. We do not consider that any institution should be eligible to receive payments unless it derives a substantial part

of its annual income from sources other than public funds and payments out of the State funds of Approved Societies.

665. We suggest that the power conferred by the section on Insurance Committees should be withdrawn as they have no funds available for this purpose.

SECTION L.—AUDIT OF ACCOUNTS.

666. We conclude this Chapter with a reference to the arrangements for audit of the accounts of Approved Societies and Insurance Committees. Though we deal with this matter briefly we do not underrate the great importance of strict and continuous supervision of the accounting of the numerous and highly diversified bodies which administer the Scheme. The question of audit only becomes prominent when misappropriation or serious negligence arises. Nevertheless, efficient audit is one of the most important elements in the financial structure of a Scheme of this character.

Results of the Audit.

667. The arrangements for audit, and the results which have emerged during the operation of the scheme are fully described in the statement which has been submitted to us by the National Insurance Audit Department (App. CI). That statement has been supplemented by a considerable measure of oral examination (Q. 23,209-23,289).

668. The evidence goes to show that, in spite of the inevitable complexity of the accounting system and the lack of professional training among the officers of many of the smaller units, the accounts are, on the whole, kept in a very satisfactory manner, and that a reasonable and increasing compliance with the many regulations of the Central Departments is secured. The following table from Appendix CI, shows a satisfactory and greatly improving state of affairs in the matter of the submission of accounts of Societies to the scrutiny of the auditors :—

	Societies.			Branches.		
	Number then coming under audit.	Number of non-compliance Special Reports.	Per cent.	Number then coming under audit.	Number of non-compliance Special Reports.	Per cent.
Year ended : 31st December, 1916	2,078	133	6·40	13,455	568	4·22
" " 1917	1,842	97	5·27	11,669	493	4·22
" " 1918	1,706	84	4·92	11,123	546	4·91
" " 1919	1,634	64	3·92	10,754	454	4·22
" " 1920	1,567	52	3·32	9,868	377	3·82
" " 1921	1,496	39	2·61	8,942	377	4·22
" " 1922	1,365	53	3·88	8,463	343	4·05
" " 1923	1,264	46	3·64	8,093	175	2·16
" " 1924	1,240	31	2·50	7,914	229	2·89

669. In the same statement we are told that, when regard is had to the aggregate amount involved in the annual transactions with State Insurance funds, the amount adversely reported upon is almost negligible. In 1924, on an expenditure of £19,000,000 audited in that year only £3,878 was thus reported, a rate of 4*s.* per £1,000. This figure shows, we think, reasonable ground for feeling that the accounting of Approved Societies is performed with honesty and accuracy.

670. The cases of fraud or failure in Insurance Committees' accounts are also few in number, and we think that that side also of the financial machinery may be regarded with satisfaction.

Employment of Professional Auditors.

671. In connexion with this branch of the work, one witness, Mr. John Reid, speaking on behalf of the Chartered Accountants of Scotland, placed before us suggestions directed to a fundamental change in the system of audit. (App LXXIX; Q. 20,342-20,534.) The provisions of the original Act of 1911 required that every Approved Society and every branch of an Approved Society should submit its accounts to audit by auditors to be appointed by the Treasury (Section 35), and there was a similar requirement in the case of the accounts of Insurance Committees (Section 60). So far as the express provisions of the Act are concerned, it would therefore have been possible to adopt the procedure which in fact governs the audit of accounts of Friendly Societies under the Friendly Societies Act, whereby, unless the alternative of a lay audit is adopted, the audit is made by a person selected from a list of professional auditors drawn up by the Treasury. In fact, however, a special Audit Department was set up for the purposes of National Health Insurance so that the audit was conducted by civil servants and not by auditors or accountants engaged in ordinary professional practice. The establishment of such a department, it will be observed, was consistent with, although not required by, the provisions of the original Act.

672. The point urged on our notice by the Chartered Accountants of Scotland was, briefly, that the disadvantages inherent in the present system are so great that the National Insurance Audit Department should be abolished and arrangements made for the work to be done by professional auditors as part of their ordinary practice.

673. In considering this question we are not a little influenced by the fact that the determination to establish a full-time service was not arrived at hastily or without mature deliberation. On the contrary it was only after carefully weighing the expedience of adopting other methods that the Inter-departmental Committee of 1912 recommended the adoption of the system now in

operation. Mr. Middleton, the Acting Chief Auditor, drew our attention to the terms of that Committee's conclusions, and we think it desirable to quote the relevant passage as it states concisely the reasons which is 1912 were regarded as justifying, and indeed necessitating, the establishment of a separate department manned by full-time officers :—

> "We find ourselves, however, strongly in favour of the employment of a whole-time staff for, at any rate, the great bulk of the work. The volume of work will be very great, and of a character at once uniform and highly specialised. It must be borne in mind also that at the inception of a new scheme of so far-reaching a nature many novel and complicated problems will arise, in dealing with which it is essential to avoid divergency of practice. The audit staff will have to be familiar with the uniform system of accounts which the Commissioners will have to prescribe, and must be made available for the purpose of giving advice and assistance generally to the various Societies in accounting matters where they so desire. We are convinced, therefore, that the appointment of a whole-time staff would not only be the most efficient but also the most economical method of meeting the immediate requirements of the situation." (*See* Q. 23,217.)

674. In essence we are satisfied that these considerations are for the most part as valid to-day as ever, and there is the further point, not to be overlooked, that an immeasurably stronger case would be required to abolish, in favour of professional audit, a system which has operated with success for 13 years than would have been necessary to justify the adoption of professional audit at a time when the field was clear. It is still true and always will be true, so far as can be foreseen, that the volume of work is "very great and of a character at once uniform and highly specialised," and where these conditions are satisfied there will, to our minds, be a *primâ facie* presumption in favour of the work being done by specialists such as are created by a full-time service rather than by professional auditors in private practice, whose wider experience of affairs at large would be a doubtful compensation for that familiarity with the work which total immersion in the complexities of the Insurance Act can alone bring.

675. Having said so much, it is perhaps unnecessary to consider in detail how much weight should properly be attached to the various considerations advanced in condemnation of the present system. But to some of these we may advert, as they appear in part to rest on a misapprehension. The delay in completing the audit of accounts which was placed in the forefront of the indictment is, we are satisfied, more apparent than real, and so far as it exists is due largely to the peculiar nature of the

transactions under the Health Insurance Act. In saying this we must not be taken as implying that delay is not a grievous fault : but we feel that such delay as exists would be manifested under any circumstances. The delay which exists is in giving the final certificate, occasioned by the fact that certain figures which must appear in the accounts can only be arrived at retrospectively, as in the determination of the sum available for administration which depends on a mean count of the membership. But delay in giving the final certificate need not, and does not involve a corresponding delay in scrutinising the transactions of Societies It does not, therefore, operate to encourage, as was suggested, the possibility of undetected fraud.

676. Nor are we satisfied that the system is an unduly expensive one. A comparison was instituted which was designed to show that on the scale of fees approved by the Treasury for similar work in the case of Friendly Societies, the work of the Audit Department could be done at approximately one-eighth of its present cost (*Reid*, Q. 20,364). But this comparison is vitiated by overlooking the fact that the Treasury Scale is not merely apportioned to expenditure but provides for a minimum fee of £3 no matter how small the unit. In considering the Health Insurance Scheme where, especially in Branch Societies, there is a large number of very small units, it is obvious that this fact is highly relevant in making any comparison, and indeed when allowance is made for the effect of the varying provisions of the Treasury scale, the comparison is by no means unfavourable to the Audit Department on the ground of expense (*Middleton*, Q. 23,220).

Qualifications of Official Auditors.

677. To one other point, that of the professional qualification of the Audit Staff, a brief reference may be permissible. It is almost unnecessary to disclaim the suggestion that the existence of the Audit Department is attributable to the fact that the accounting system under the Insurance Act is so intricate that no ordinary professional accountant could understand it (App. LXXIX, 2). Intricacy of accounts is obviously a reason for entrusting the work of audit to men of high professional skill, and we consider it important that the staff of the Audit Department should comprise as large a proportion as practicable of men with professional qualifications. When the Audit Department was established, a considerable number of those recruited were men with professional qualifications, and at present, as we are informed, the staff contains 38 Chartered Accountants and 61 Incorporated Accountants (*Middleton*, Q. 23,223-23,224). At present, however, men with professional training or experience are not being recruited. These men receive " an intensive training. It is not as broad as the professional qualification. It

is not required to be so broad, but it is very intensive." (*Middleton*, Q. 23,234.) Moreover, they are encouraged, and many of them in fact prepare themselves, to take the Incorporated Accountants' examinations. This is as it should be, but it is perhaps a matter for consideration whether the encouragement might not be more encouraging, or alternatively more imperative. Accountancy is after all a profession, and on general grounds it is desirable that those who in the service of the Government do work which is proper to any profession, should be professionally qualified. It may be that the " intensive training " which the young and unqualified auditor receives may make him within his own narrow plot as useful as a qualified accountant; but we feel that if a professional qualification is of any value, its attainment should enable the holder to bring to the discharge of his duties a wider outlook which, even if only in undefined ways, would promote the efficiency of the service. Nor in this matter do we think it right to overlook the increased respect with which the public at large (whether ignorantly or not is irrelevant) would probably regard men professionally qualified to do professional work.

678. In summary, therefore, we do not recommend any change in the existing system of auditing the accounts of Approved Societies and Insurance Committees, but we consider that every effort should be made to keep the proportion of qualified men on the staff at as high a level as is practicable.

CHAPTER XIV.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS.

In this Chapter we give a summary of the conclusions at which we have arrived and the recommendations which we submit. The numbers of the relative paragraphs of the Report are given for convenience of reference

General.

(1) That National Health Insurance has established its position as a permanent feature of the social system in this country, and should be continued on its present compulsory and contributory basis subject to the various changes recommended below. (para. 28.)

Persons to be included in the Scheme.

(2) That to the persons at present required to be insured as employed contributors should be added persons engaged in employment under a contract for the performance of manual labour for the purpose of any trade or business except in so far as such employment may be excluded by a Special Order. (paras. 464-468.)

(3) That except for the addition of the class referred to in (2) above, there should be no change, either in respect of the age limits or the rate of remuneration test or otherwise, with regard to the persons required to be insured as employed contributors or allowed to be insured as voluntary contributors. (paras. 456-463, 474.)

Revenue of the Scheme.

(4) That the revenue of the Scheme should continue to be derived from contributions from insured persons and (in the case of employed persons) their employers, together with a payment from the National Exchequer of a proportionate part of the cost of the benefits and of their administration. (paras. 28 and 153.)

(5) That the cost of the central administration of the Scheme should continue to be a charge on the Exchequer. (para. 153.)

(6) That beyond the payment of the proportionate part of the cost of benefits and administration and the cost of supervision by the Central Departments, there should be no charge on the Exchequer in respect of National Health Insurance. (para. 153.)

Development of the Health Services.

(7) That the various Medical Services organised by the State will continue to expand both in their scope and in the range of persons to whom they apply. (paras. 55-56, 115.)

(8) That these services should be maintained in close relationship with each other, both at the centre and in their local administration. (para. 123.)

(9) That in considering any changes or developments in the Insurance Medical Service regard should always be had to the importance of the fullest possible co-ordination with other health services. (paras. 115, 120.)

Medical and Treatment Benefits.

(10) That medical benefit has been a valued and successful element in the Scheme of National Health Insurance. (para. 74.)

(11) That while it has been inevitable hitherto that medical benefit should be confined to a general practitioner service, this limitation has detracted from the value of the benefit and its removal is urgently desirable. (para. 261.)

(12) That the additional benefits of a treatment character have been, on the whole, successful and appreciated, though in varying degrees, but that they suffer from the following defects inherent in the conditions under which they are provided :—

(*a*) They are only available for those insured persons who are members of Societies having surpluses at valuation, and only for those members who fulfil certain qualifying conditions, and that consequently large classes of insured persons are debarred from participating in these valuable services.

(*b*) Even among the Societies giving a particular type of treatment benefit there is no uniformity in the content of the benefit, with the result that there is widespread confusion in the minds of the insured persons as to what precisely their rights are.

(*c*) The arrangements made between Societies and professional bodies are wanting in authority and uniformity, and in some cases are accompanied by undesirable conditions (para. 81.)

Maternity Benefit.

(13) That it is desirable that, as soon as funds are available, the scope of maternity benefit should be expanded to cover medical and midwifery services in addition to a cash payment; that the service element should then be administered by the local Health Authorities and be co-ordinated with the other local medical services; and that a cash element should be retained

and be administered in connexion with the other cash benefits. (paras. 114 and 343.)

THE FINANCIAL BURDEN OF THE EXISTING SOCIAL SERVICES.

(14) That the financial burden of the various social services is at the present time so great in proportion to the productive capacity of the country, and so much in advance of what is provided in countries which are our trade competitors, that no extensions of benefit involving substantial additional expenditure should be contemplated now or in the immediate future, but that any immediate changes in the Scheme of National Health Insurance should be limited to such as are possible within its present financial resources. (paras. 151-153.)

(15) That accordingly there should be no increase at the present time in the rates of contribution or in the scale of the Exchequer Grants. (para. 153.)

THE FINANCIAL RESOURCES OF THE NATIONAL HEALTH INSURANCE SCHEME.

(16) That the financial arrangements of the Scheme are well devised, and that the machinery works smoothly and effectively. (para. 155.)

(17) That an analysis of the expenditure of Approved Societies on sickness and disablement benefits reveals the need for more effective supervision of claims for those benefits, and that the attention of the Central Departments should be directed to the matter so that they may consider in co-operation with the Approved Societies more effective methods of supervision. (paras 176-177.)

(18) That by a modification of the actuarial basis of the Scheme, particularly with regard to expectation of sickness and assumed rate of interest as set out in the First Report of the Actuarial Committee, and by certain financial readjustments described below, a margin can be made available out of the present weekly contribution which, with the related State grant, will provide a sum of about 7*s*. a year in the case of men and 3*s*. 9*d*. a year in the case of women. (para. 179.)

(19) That the first charge on this margin should be the provision of the balance (estimated at 3*s*. per insured person per annum, both for men and women) of the cost of the present medical benefit for which no statutory provision has been made beyond the end of 1926; further that any deficiency in respect of the cost of medical benefit for the three years 1924-1926 should be met by an increase of the charges imposed by the National Health Insurance (Cost of Medical Benefit) Act, 1924 upon the moneys to which recourse is authorised by that Act. (para. 182.)

(20) That the balance of the margin should not be devoted to decreasing the present weekly contribution, but should be

applied to its full extent towards meeting the cost of extending the statutory benefits. (paras. 183-186.)

(21) That Section 67 of the Act should be amended to provide that the amount of the weekly contribution to be devoted to providing interest on and redemption of reserve values be reduced from 1*d.* in the case of men and from nine-tenths of 1*d.* in the case of women to such amounts as may be actuarially shown to be necessary without disturbing the redemption period, after the charges and readjustments have been settled. (para. 194.)

(22) That Section 67 should also be amended to provide that the amount of the weekly contribution to be retained for the purposes of the Contingencies Funds and Central Fund should be reduced from five-ninths of 1*d.* to one farthing in the case of men, and from two-fifths of 1*d.* to one farthing in the case of women. (para. 194.)

(23) That the maximum proportion of these reduced sums to be paid to the Central Fund should be increased from one-eighth to one-fourth. (para. 194.)

(24) That Section 76 (5) of the Act should be amended to provide that consequentially on the reduction of the contribution to the Contingencies Funds, the whole (instead of a maximum of one-half) of the balances of the Contingencies Funds of all Societies with less than 1,000 members should be liable to be pooled to make good deficiencies in any such Societies. (para. 194.)

(25) That the balances accruing to the credit of the Reserve Suspense Fund after the 31st December, 1926, should be made available for averting deficencies which would otherwise arise on the valuation of Approved Societies by reason of the imposition on their funds of the proposed new charges. (para. 194.)

(26) That consequent upon the placing of the liability for the whole cost of medical benefit on the funds of Approved Societies, the appropriate changes should be made in the rates of contribution of men serving with the Forces of the Crown, foreign-going seamen of the Mercantile Marine, and voluntary contributors with incomes exceeding £250 a year and that, in the event of the provision of allowances for dependants of insured persons, a further appropriate adjustment should be made in the contribution payable in respect of men serving in the Forces of the Crown. (paras. 191-193.)

The Approved Society System.

(27) That the Approved Society system as a means for the administration of the cash benefits of National Health Insurance should be retained, but that this question might have to be reconsidered in the event of fundamental changes being made in the system of social insurance. (paras. 222-223.)

(28) That the administration of additional benefits of the nature of treatment should remain in the hands of the Approved Societies in so far as the consideration of claims for benefit is concerned. (para. 228.)

(29) That where a treatment benefit has been so widely adopted as an additional benefit as to be available for a large proportion of the total insured population, the negotiations as to terms and conditions of service with the profession by whom the service is provided should be undertaken by the Central Departments, and that the organisation and supervision of the service should rest with those Departments either directly or through the agency of the local bodies responsible for the administration of medical benefit. (para. 228.)

(30) That Section 22 (1) of the Act should be amended so as to empower the Minister in any case in which the rules of a Society do not in the view of the Department adequately provide for its proper government, or are likely to operate unfairly to the prejudice of members, to give notice to the Society not less than one month before a general meeting, to consider an amendment of any rule to which exception is taken; and if the rule is not so amended, to make an Order directing that the amendment desired shall be deemed to be incorporated in the rules; and that appropriate machinery for dealing with objections should be set up. (para. 240.)

(31) That in the case of centralised Societies there should be only one tribunal for the determination of disputes between Societies and their members, before reference to the Minister, and that in the case of Societies with branches not more than two such tribunals should be allowed, namely the branch tribunal and a tribunal of the District to which the branch is attached, or of the central body of the Society. (para. 241.)

(32) That provision should be made by an extension of Section 38 of the Act whereby the Department should have power to hold an inquiry into the methods of administration of any Society where the administration of the Society is regarded as unsatisfactory in any respect; and that if the Department is satisfied that it is not in the interest of the insured members that the Society should continue to be approved, the Department should have power to require it to arrange for the transfer of its engagements to some other Society. (para. 242.)

(33) That it is inexpedient to impose any statutory restriction on the size of Societies. (para. 230.)

(34) That in any case in which the Minister is satisfied that the administration of a Society or branch does not conform to a reasonable standard of efficiency he should be empowered to order a reduction as he may think fit, of the amount allowed to the Society for administration purposes. (para. 242.)

(35) That the members of an international Society resident in any national areas other than that in which the head office of the Society is situated should be given a further opportunity of electing, subject to the consent of the central body of the Society, to have a combined valuation for the whole Society; but that no new option should be given to international Societies to be valued separately in respect of each part of the United Kingdom in which they operate. (paras. 562-563.)

(36) That Section 30 (2) should be amplified so as to provide that where the number of members of an international Society who are resident in any national area other than that in which the head office of the Society is situated is less than a definite percentage of the total membership and is not more than a certain number, approval may be withdrawn in respect of that area and the members resident therein should be deemed to be resident in the area in which the head office is situated. (para. 606.)

(37) That where at a general meeting of an Approved Society with branches a resolution in favour of the centralisation of the branches either wholly or in districts is passed by such substantial (e.g., four-fifths) majority representative of the insured members as may be prescribed, such resolution should, subject to prescribed conditions, be binding on all branches of the Society. (para. 609.)

(38) That the provisions of Section 76 for the pooling of the Contingencies Funds of small Societies through associations should be repealed, but that existing associations be allowed to continue on a voluntary non-statutory basis for the purposes of consultation and general co-operation. (para. 567.)

(39) That Section 72 should be amplified so as to give to the Auditors powers of disallowance and surcharge in the case of improper expenditure by Approved Societies. (para. 244.)

Partial Pooling of Surpluses.

(40) That while the possibility of the existence of differences in the benefits provided by different Societies may justifiably be continued as a feature of the Scheme of National Health Insurance, the disparities which have emerged are greater than are expedient in the interests of the insured community regarded as a whole; and that, therefore, some mitigation of these inequalities is desirable. (para. 255.)

(41) That to effect this result, a scheme of partial pooling of surpluses on the following lines should be instituted :—

(*a*) No surplus (including Contingencies Fund) which has accrued prior to the change of system should be subject to pooling, and thereafter pooling should apply only to such part of a surplus as has accrued since the date of the last

preceding valuation, i.e., at each valuation the surplus carried forward from the previous valuation (including the Contingencies Fund) with its interest earnings, would be exempted from the operation of the scheme. (para. 256.)

(*b*) The proportion of the surplus specified above, which should be subject to pooling, should be one-half. (para. 257.)

(*c*) The fund constituted by the half surpluses in question should be distributed among the benefit funds of all Societies at a uniform rate per head of membership. (para. 258).

Extensions of Benefits.

(42) That the extensions of statutory benefits, to be made as and when funds are available to meet the cost, should be placed in the following order of priority :—

(*a*) Extension of the scope of medical benefit. (paras. 261-262.)

(*b*) The provision of allowances in respect of dependants of insured persons in receipt of sickness or disablement benefit. (paras. 314-326, 343.)

(*c*) Improved provision at the time of pregnancy and childbirth for insured women and the wives of insured men. (para. 343.)

(*d*) The provision of dental treatment as a normal benefit (para. 361.)

(43) That the extension of the scope of medical benefit should take the form of the provision of

(*a*) expert medical advice and treatment for persons who can travel to meet the specialist;

(*b*) expert advice for persons who are unable to travel;

(*c*) laboratory services;

but that in-patient treatment in hospitals, major operations in the home, maternity services and dental services should not be included at present. (paras. 263-268.)

(44) That the extended service should be provided not by way of development of the out-patient work of the hospitals, but through an independent scheme organised, under the general direction of the Ministry, throughout the whole country by the Insurance Committees or their successors, as an integral part of medical benefit. (para. 277.)

(45) That in the scheme provision should be made for the closest co-operation between the general practitioners and the specialists, particularly for the exchange of information as to cases and for the giving of definite guidance to the general practitioner as to both diagnosis and treatment. (para. 277.)

(46) That any practitioner possessing the requisite qualifications should be entitled to take part in the work, and that the decision as to whether particular practitioners possess these qualifications should lie in the hands of a mixed lay and medical committee for each area. (para. 283.)

(47) That in the initial stages of the scheme arrangements might be made for patients who are able to travel to attend either at the specialist's consulting rooms or at the out-patient departments of hospitals, or at clinics established by the local administrative authority, as may be found most convenient in various areas. (para. 284.)

(48) That the scheme of extended medical benefit could be financed through the funds made available under the scheme of pooling of surpluses referred to in recommendations (40) and (41). (para. 259.)

(49) That ophthalmic benefit should be recognised as part of the expert out-patient service under the scheme, and should not be available except on the recommendation of a medical practitioner. (paras. 88 and 90.)

(50) That an increase in some form of the normal cash benefit payable during incapacity for work is very desirable. (para. 308.)

(51) That for financial reasons this increase must at present be limited to an allowance in respect of dependants, where sickness or disablement benefit is payable, on the following lines :—

(*a*) An addition to the sickness benefit of 2*s*. a week in respect of each dependant.

(*b*) An addition to the disablement benefit of 1*s*. a week in respect of each dependant.

(*c*) The dependants' allowance should be paid in all cases of incapacity of an insured married man even where the wife is herself a wage earner.

(*d*) The dependants' allowance in respect of dependent children should only be paid from the husband's insurance, not from the wife's.

(*e*) The dependants for the purposes of the scheme should normally be the wife and the children up to 14 years of age, but in order to meet the case of the widower with dependent children, an additional 2*s*. in the case of sickness benefit and 1*s*. in the case of disablement benefit should be paid in such case.

(*f*) In the case of the insured widow with dependent children, the allowance should be paid only in respect of the children and no additions similar to those in (*e*) should be made thereto.

(*g*) In the case of the insured woman whose husband is uninsured, no allowances in respect of dependent children should be paid from the woman's insurance.

(*h*) In the case of unmarried insured women, no allowances should be paid in respect of dependent children, but additions at the rates of 2*s*. to sickness benefit and 1*s*. to disablement benefit should be paid in respect of a widowed mother living with the insured person and not having sons to whom she can look for support. (paras. 314-326.)

(52) That no change should at present be made in the existing provision for maternity under the Insurance Scheme. (para. 347.)

(53) That while a complete dental service available to the whole insured population would be an eminently desirable addition to the Insurance Scheme, no such change is financially practicable at present, and that therefore the general arrangements for dental services under additional benefit schemes be continued. (paras 348, 361.)

(54) That in order to secure more uniformity in, and effective supervision of, these services a Regional Dental Staff be instituted in such a form that it may be appropriately expanded when a statutory dental benefit is feasible; and that a substantial proportion of the cost of the Regional Dental Staff be borne by the Approved Societies providing dental benefit.(paras. 362-365.)

(55) That owing to considerations arising from a survey of the development of the various medical services provided or supervised by the State and having regard to the very large cost involved, no extension in the direction of provision of medical benefit for the dependants of insured persons be made. (para. 373.)

Insurance Committees.

(56) That Insurance Committees be abolished and their powers and duties transferred to committees of the appropriate Local Authorities, such committees to contain possibly a proportion of co-opted members. (para. 396.)

Remuneration and Control of Insurance Practitioners.

(57) That the capitation method of remuneration of the insurance practitioners be continued as the normal method but that the attendance method be retained as an alternative for adoption in particular areas when so desired. (para. 431.)

(58) That it is desirable that any settlement of the rate of remuneration of the insurance practitioners should be made valid over a reasonable period of years so as to avoid financial uncertainty to both the contracting parties. (para. 428.)

(59) That the existing machinery for regulating admission to and removal from the medical panel, and for dealing with complaints as to the conduct of practitioners, chemists and patients

is necessary and operates fairly; and should, subject to (60) below, be continued generally in its present form. (paras. 438-449.)

(60) That where, on an inquiry resulting from representations that an insurance practitioner should be removed from the panel, it is decided that such removal is not justified, the practitioner should be given an opportunity of a further hearing before any lesser penalty is imposed by the Minister. (para. 448.)

Payment and Collection of Contributions.

(61) That the present system for the payment and collection of contributions by means of stamps and cards has operated satisfactorily and should be continued but that the powers of the Central Departments for securing compliance with the provisions of the Act in this respect should be strengthened as indicated in the following recommendations. (para. 476.)

(62) That Section 96 (1) of the Act should be modified so as to render liable to prosecution any person who makes a fraudulent statement with a view to avoiding compliance with the Act. (para. 478.)

(63) That Section 97 (1) (*a*) of the Act should be amended to provide that proceedings for any of the offences specified in Section 96 (2) and (3) may be brought at any time within one year from the date of the commission of the alleged offence. (para. 478.)

(64) That the offence of trafficking in stamps (Section 96 (3)) should be made subject to the penalty of imprisonment as an alternative to a fine. (para. 478.)

(65) That the preferential period for the recovery of unpaid contributions in the case of bankruptcy or companies in liquidation (Section 106 (1)) should be extended from four months to 12 months. (para. 478.)

(66) That Section 97 should be so extended as to make directors of companies who are actively engaged in the conduct of the company's business personally liable for the non-payment of contributions due in respect of the company's employees unless they can show that they could not reasonably be expected to have had knowledge of the default. (para. 478.)

(67) That the proposal to pay out of Health Insurance funds contributions unpaid owing to bankruptcy should not be adopted. (para. 479.)

Administration of Normal Benefits.

(68) That the proviso to Section 13 (4) of the Act, which provides for penalties on insured persons who fail to give notice of their illness at the proper time should be amended so as to free from penalty an insured person who had reasonable excuse for his failure to give notice. (para. 483.)

(69) That Section 13 (5) of the Act should be amended so as to provide that an illness shall not be treated as a continuation of a former illness if in the period of 12 months immediately preceding the commencement of the illness the insured person has had only short periods of incapacity amounting to not more than six days in the aggregate. (para. 487.)

(70) That in the case of insured persons who, during incapacity, are inmates of any of the institutions mentioned in Section 17 of the Act the amount of accumulated sickness and disablement benefit payable to the insured person on leaving the institution, or to his legal representatives on his death in the institution, shall be limited to £50, and that the balance of the accumulated benefit over and above this sum shall be paid into the Central Fund at yearly or half-yearly intervals. (para. 491.)

(71) That any sum representing accumulated sickness and disablement benefit payable to an insured person on leaving an institution shall, in all cases, be paid in instalments at a weekly rate equal to the rate of sickness benefit normally payable by the Society of which he is a member. (para. 495.)

(72) That the attention of Societies should be directed to the provisions of Section 17 (2) (*b*) of the Act under which they are empowered to make payments towards defraying expenses of members during their stay in an institution, and that Societies should be encouraged to make fuller use of that power by meeting the cost of small additional comforts for their members in such circumstances. (para. 496.)

(73) That provision should be made to empower Societies to recover (without prejudice to any existing rights of recovery) overpayments of benefit made to a member, by withholding each week from sickness or disablement benefit due in respect of subsequent periods of incapacity occurring within 12 months of the date on which the overpayment was brought to the notice of the member an amount not exceeding one-third of the weekly sum then payable as benefit. (para. 502.)

(74) That Section 25 of the Act, which empowers the Minister to provide for the re-insurance with him of the liabilities of all Approved Societies in respect of maternity benefit, should be repealed. (para. 511.)

Additional Benefits.

(75) That in the case of new entrants into insurance no change should be made in the present position as regards title to additional benefits. (para. 585.)

(76) That in the case of persons transferring from one Approved Society to another the title to participate in the additional benefits—whether cash or treatment benefits—provided by the new Society should mature at the end of two years

after the date of transfer; and that the transfer value should continue as at present to represent the liability in respect of normal benefits only. (para. 585.)

(77) That in order to provide a safeguard against the risk of excessive transfers to any Society in consequence of the preceding recommendation, the Minister should be given power to suspend the right of any Society to accept members by way of transfer if the membership of the Society has been increased in this way since the date of the last valuation by more than a prescribed proportion. (para. 587.)

(78) That in the case of transfers between branches of the same Society the branch to which a member transfers should be given the option of allowing him to participate in all additional benefits immediately. (para. 588.)

(79) That Section 75 (1) (*a*) of the Act should be amended so as to provide that where the valuer certifies that a substantial part of the surplus of a Society has accrued in respect of members who have ceased, or are likely to cease shortly to be insured as employed contributors by reason of passing over the income limit, the scheme of additional benefits may, subject to the approval of the Minister, provide for an extension of the period during which additional benefits, other than cash benefits, may be allowed after membership has ceased to persons who are at the valuation date, or within a period prescribed by the scheme have been, members of the Society. (para. 590.)

(80) That Section 75 (4) should be amended so as to provide that the conditions under which persons should be entitled to participate in additional benefits shall be as prescribed. (para. 579.)

(81) That provision should be included in Section 75 of the Act which will limit the period of currency of additional benefit schemes to such period as may be fixed by the Minister. (para. 571.)

(82) That Section 75 (2) should be amplified so as to provide that all schemes of additional benefits shall be subject to Regulations in force at the time, and that the Minister should have power to make and amend these Regulations as and when necessary. (para. 576.)

(83) That Section 75 should be amplified so as to provide that the Treasury Valuer, in certifying what part of a realised surplus is disposable, shall have regard to the desirability of maintaining the additional benefits available out of that surplus beyond the period of currency of the scheme. (para. 574.)

(84) That it is not desirable to lay down any statutory limit to the extent to which a Society may provide out of its surplus an increase of cash benefits, but that the question of the disposal of a surplus on a reasonable basis should be determined

in accordance with the wishes of the members, subject to approval by the Central Department. (para. 605.)

(85) That the list of additional benefits contained in the Third Schedule to the Act, which may be provided by Societies having a disposable surplus on valuation, be amended as indicated below :—

(*a*) The following additional benefits should be removed from the list :—

Medical treatment and attendance for any person dependent upon the labour of a member. (*No.* 1.)

Payment of a disablement allowance to members though not totally incapable of work. (*No.* 5.)

Payment of pensions or superannuation allowances, whether by way of addition to Old Age Pensions under the Old Age Pensions Act, 1908, as amended by any subsequent enactments, or otherwise. (*No.* 9.)

Payment, subject to the prescribed conditions, of contributions to superannuation funds in which the members are interested. (*No.* 10.)

(*b*) The following alterations should be made in certain other additional benefits included in the list :—

That benefit *No.* 3 should be restricted to an increase of sickness benefit and disablement benefit.

That benefit *No.* 4 should be confined to the payment of sickness benefit from the first day of incapacity.

That benefit *No.* 11 should be limited to payments to members who are in want or distress.

(*c*) The additional benefits which are at present prescribed by Regulations should be included in the Schedule.

(*d*) A new additional benefit, viz., the payment of the whole or part of the cost of massage and electrical treatment, should be added to the list. (paras. 591-600.)

Special Classes of Insured Persons.

Deposit Contributors.

(86) That the Deposit Contributors Fund should be divided into two sections, viz. : (*a*) an " Individual Account Section " on the present basis and (*b*) an " Insurance Section " on a mutual basis, the latter Section to include only such persons as satisfy the Minister that by reason of the state of their health they are unable to obtain admission to an Approved Society. (paras. 410-412.)

(87) That the payment to a deposit contributor or his legal representatives of half the balance standing to his credit on his emigration or death should be discontinued. (para. 410.)

(88) That the revenue of the " Insurance Section " of the Fund should be derived from (*a*) the contributions of the members of that Section, (*b*) the appropriate State grants, (*c*) the

balance of the accounts of deposit contributors in the "Individual Account Section" released on death or emigration, and (*d*) the accruing interest on the whole Fund. (para. 411.)

(89) That in so far as any surplus revealed on a valuation of the Insurance Section of the Fund is attributable to the additional sources of revenue referred to in (*c*) and (*d*) above, it should be paid into the Central Fund. (para. 414.)

(90) That in the "Insurance Section" of the Fund the normal benefits of the Act, but not additional benefits, should be paid. (para. 411.)

(91) That the "Insurance Section" of the Fund should be placed in the same position as an Approved Society as regards payment into a Contingencies Fund and the Central Fund and recourse to those Funds. (para. 413.)

(92) That the accumulation of interest in the Deposit Contributors Fund up to the date of instituting the proposed new system be transferred to the Reserve Suspense Fund. (para. 417.)

Married Women.

(93) That special provision should continue to be made for insured women who cease employment on marriage (Class K). (para. 523.)

(94) That the test for transfer to the special class should continue to be absence from work for a period of eight consecutive weeks within one year of marriage, but that any weeks during which a woman is away from work by reason of sickness should not be counted towards these eight weeks, and that a similar concession should be made in respect of weeks of genuine inability to obtain work, subject to arrangements being made for obtaining satisfactory evidence of unemployment in accordance with recommendation (117). (para. 523.)

(95) That the benefits under the special scheme of insurance should remain as at present, except that benefit during sickness should in all cases be paid at the sickness benefit rate. (para. 524.)

(96) That maternity benefit should in all cases be paid in full in respect of the first confinement occurring within two years of the marriage but that, with this exception, women in Class K should be subject to the ordinary provisions as to arrears. (para. 525.)

Exempt Persons.

(97) That the class of exempt persons should be retained, and that their title to medical benefit should not be withdrawn. (para. 532.)

(98) That the income limit beyond which exempt persons should be required to make their own arrangements for medical benefit should be raised from £160 to £250 a year. (para. 533.)

Forces of the Crown.

(99) That the benefits payable out of the Navy, Army and Air Force Insurance Fund to discharged men who are established as permanent members of the Fund, should in future include additional benefits equivalent, as near as may be, to the average of those provided by Approved Societies in general. (para. 542.)

(100) That members of the Navy, Army and Air Force Insurance Fund who transfer to an Approved Society on their discharge from the Forces should, for the purpose of title to additional benefits, be treated as though they had been members of the Society from the date of their joining the Forces, and that to enable this to be done the transfer values payable out of the Navy, Army and Air Force Insurance Fund in respect of such men should be augmented by the estimated share of surplus earned during their period of service. (para. 542.)

(101) That apart from the modifications in (26) and (100) above, no change should be made with regard to the insurance of men serving in the Forces of the Crown. (para. 540.)

Mercantile Marine.

(102) That the card system of collection of contributions of foreign-going seamen of the Mercantile Marine should be abandoned and a schedule system instituted. (para. 547.)

(103) That while it would be of great advantage that all foreign-going seamen should be included in one or two Approved Societies only, it is not desirable that there should be statutory provision to this effect. (para. 550.)

(104) That the special arrangements under Section 63 (5) for providing medical benefit to members of the Seamen's National Insurance Society be discontinued, and that members of the Society should in future receive their medical benefit under the normal arrangements. (para. 552.)

(105) That all persons who have served in the British Mercantile Marine, whether members of Approved Societies or not, should be eligible for pensions from the Lascar Fund. (para. 555.)

(106) That Section 64 (5) of the Act should be amended so as to provide that the cost of administering the Lascar Fund should be borne by the Fund itself. (para. 557.)

(107) That the State Grant on pensions or other benefits payable out of the Lascar Fund should be withdrawn. (para. 558.)

MISCELLANEOUS.

(108) That no change should be made in the provisions of Sections 70 and 71 of the Act relating to the investment of the funds of Approved Societies. (para. 617.)

(109) That subject to recommendations (34) and (110) no change should be made in the existing provision relating to the

maximum amount available to Approved Societies for the purposes of administration. (para. 619.)

(110) That the arrangements under which certain Societies are allowed to contract with their private sides or parent bodies for the performance of State Insurance work should not be prohibited, provided that the arrangements made are such as to secure a substantial advantage to the insured members in respect of the sum appropriated for the cost of administration; and that the Central Departments should scrutinise closely from this point of view the terms and conditions of any proposed arrangement of this kind before giving their approval. (para. 621.)

(111) That any arrangement under which the bulk of the money available for the purposes of administration of a Society is paid to the secretary of the Society, who then undertakes to contract for the whole of the administrative work of the Society, should be prohibited. (para. 622.)

(112) That no increased administration allowance should be made in respect of mercantile marine members. (para. 553.)

(113) That Section 16 (1) (*c*) of the Act, which requires employers to notify compensation agreements to the Minister, should be repealed. (para. 631.)

(114) That provision should be made whereby in any case in which an award of compensation or damages has been made in favour of an insured person, and the payment cannot be recovered by reason of the insolvency of the employer or other person liable, sickness or disablement benefit should then become payable. (para. 629.)

(115) That Section 26 of the Act should be repealed, and that provision should be made whereby Societies may, when formulating schemes of additional benefits, allocate a specific sum out of their disposable surpluses for the purpose of making payments to charitable institutions, this provision to be submitted as part of the Scheme and to be subject to the same scrutiny and control by the Central Department as are the proposals for additional benefits; that it is desirable to define in fairly precise terms what constitutes a charitable institution; and that the powers conferred by the section on Insurance Committees should be withdrawn. (paras. 664-665.)

(116) That so far as the powers of the Central Department to hold enquiry into excessive sickness are concerned, the penal provisions of Section 107 of the Act are useless and should be eliminated; but that the bodies responsible for the local administration of medical benefit to insured persons should be given power to institute inquiry into cases of excessive sickness brought to their notice, and for this purpose to utilise the medical records of insured persons resident in their areas. (paras. 637-638.)

(117) That it is desirable to make permanent provision which will protect an insured person from incurring any loss or penalty

by reason of arrears due to genuine certified unemployment. (para. 655.)

(118) That no departure should be made from the principle that the benefits derived from the compulsory contributions of employers and employed persons should not be applied towards the relief of local rates, and that provision should not therefore be made for payments to Poor Law Authorities out of the sums accruing as benefit in the case of insured persons who are inmates of Poor Law Institutions and have no dependants. (para. 493.)

(119) That it is open to question whether propaganda work undertaken in the interests of the health of the whole community should be financed only from insurance funds; that the duties should more appropriately fall within the province of the Local Health Authority, particularly having regard to the provisions of Section 67 of the Public Health Act, 1925. (para. 391.)

(120) That Section 24 (3) of the Act should be amended so as to debar any Insurance Committee or Local Authority succeeding to its powers and duties from approving in future any organisation for the purpose of "collective own arrangements" for medical benefit, and to provide that the provisions of the subsection shall not be applied otherwise than to individual insured persons; subject to the qualification that the proposed restriction should not apply to cases in which nurses or other resident employees of hospitals normally receive medical treatment and attendance from the medical staffs of the hospitals in accordance with the terms of their employment. (para. 647.)

(121) That existing medical institutions which have already received recognition under Section 24 (3) should be continued, approval being given to them under Section 24 (4). (para. 648.)

(122) That while there is no evidence of failure sufficient to justify the recommendation that existing medical institutions under Section 24 (4) should no longer be recognised, approval should not be given to any further such institutions except as provided in (121) above; and that no rule of any such institution should purport to debar a member of the institution from carrying an appeal as to his medical treatment to the Insurance Committee of the area. (para. 643.)

In concluding our Report we wish to express to Your Majesty our high appreciation of the invaluable services rendered to us by our Secretary, Mr. E. Hackforth, of the Ministry of Health, and our Assistant Secretary, Mr. J. W. Peck, C.B., of the Scottish Board of Health, both throughout the long course of the hearing of evidence and in connexion with the exacting work of the preparation of our Report.

In such an investigation as that on which we have been engaged, where the points at issue are often concealed in the

complexity of administrative provisions and obscured by much unwritten history, the work of the Secretary is particularly onerous and calls for the utmost degree of efficiency and accuracy. Mr. Hackforth has brought to our guidance and has held ever ready at our disposal an intimate and highly technical knowledge of the intricacies and the development of Health Insurance law and procedure; and our task has been materially lightened by the great ability and exactitude with which he has handled, collated and amplified the immense volume of written and printed matter submitted to us. Throughout all our inquiries we have been greatly indebted to Mr. Hackforth and Mr. Peck for their unfailing courtesy, their resourcefulness, and their readiness on all occasions to comply with the many demands made upon their time and their knowledge.

We also acknowledge our obligations to the members of the staff of the Ministry of Health, the Scottish Board of Health, and the Government Actuary's Department, who have prepared material for our use. In particular we desire to express our indebtedness to the anonymous and unrecorded authors and compilers of the "Summary of the Law and Administration of National Health Insurance" which has been printed as Part I of the Appendix to the Minutes of Evidence taken before us—a work which has not only been throughout of incalculable assistance to us, but will also, as we anticipate, afford the greatest enlightenment to all independent inquirers in this comparatively neglected field of social study and research.

All which we humbly submit for Your Majesty's gracious consideration.

(Signed) Lawrence of Kingsgate (*Chairman*).

John Anderson.

Humphry Rolleston.

Alfred W. Watson.

Arthur Worley.

Andrew R. Duncan.*

Arthur Digby Besant.

Alexander Gray.*

William Jones.

E. Hackforth (*Secretary*).

J. W. Peck (*Assistant Secretary*).

22nd February, 1926.

* Signatures subject to the Reservation which is appended.

RESERVATION BY Sir ANDREW DUNCAN AND Professor ALEXANDER GRAY.

1. While concurring in the terms of the Report signed by the majority of our colleagues, we consider that there are two further matters which ought not to be ignored in any review of the problems presented to us, more particularly if due weight is to be given to the reactions of our social legislation on the trade and industry of the country. In supplementing our assent to the Majority Report with certain observations on these points, we postulate, as an elementary principle, that in promoting schemes of social legislation the State should avoid incurring any expenditure which is not essential to the achievement of the end in view, and further, that the funds, required and collected by its authority, should be so collected as to involve a minimum disturbance to industrial enterprise.

2. The first point to which we wish to draw attention—the lack of co-ordination in our social services—is one which has been the subject of comment in many quarters. We desire in this place to point out the inconvenience, and by implication the waste, which it occasions. In a sense this question may not be within our Terms of Reference, but it is impossible to survey the field of Health Insurance without realising that the problems of Health Insurance are closely interwoven with wider questions from which, in fact, they cannot be divorced. It would be unjust to say that our social legislation has grown up haphazard, but it is indubitable that the various schemes contrived for the protection of the worker against the accidents of life have been elaborated—doubtless very properly—as and when occasion offered. Poor Law Relief, Old Age Pensions, Health Insurance, Unemployment Insurance, Widows' Pensions have grown up in large measure independently : when they are reviewed, they are reviewed independently. They are financed in different ways; they are operated by different agencies. On the possibility of co-ordination, on the alternative methods and machinery of operating a co-ordinated scheme, we have received no evidence, or only incidental evidence; and on all such matters we express no opinion. But we do desire to emphasise that there is here a problem which calls for urgent consideration. It may be that in a co-ordinated scheme different machinery would still be necessary for the administration of different sections of the work undertaken but *prima facie* it appears reasonable to assume that an economy of expenditure and of effort would be effected by viewing the problem of social insurance as a whole and not sectionally.

3. While we do not dissent from the present arrangements under which the employer's contribution is on a flat rate pro-

portioned to the number of employees, we doubt whether in discussions on the reactions of the cost of Health Insurance on the trade and industry of the country, the consequences of the present arrangements are always appreciated. At present the contribution made by employers to the Health Insurance Fund is roughly proportioned to the wages bill, but the wages bill has no necessary relation to the profits of a firm. In consequence, a firm employing a large staff will contribute largely to the Health Insurance Fund, even though it be in a depressed trade and may not at the time be covering even overhead expenses; on the other hand, provided it employs few men, a prosperous firm will contribute but little. It follows from this that the ultimate incidence of the tax and its reaction on trade may vary greatly from one industry to another. In certain cases it may doubtless be possible in large measure to pass the burden on to the consumer; elsewhere this may be wholly impossible. When account is taken of the further contributions for Unemployment Insurance and Widows' Pensions very large sums may be involved in the case of a firm employing many men, and in extreme and unfavourable circumstances the burden of the social services may become almost crippling. We consider it all the more important to emphasise that there can be no easy generalisation as to the incidence and the effects of the insurance contribution, since so eminent a writer as Mr. R. G. Hawtrey has recently lent the weight of his authority to the doctrine that "the employer's share falls on the workmen just as much as the rest" and he describes as a "transparent device" the arrangement under which a part of the cost is "ostensibly" imposed on the employer. We are not aware of anything either in economic theory or in actual practice which justifies this conclusion. The burden imposed by social insurance on industry is in certain cases very real and, unfortunately, it is at present most onerous where there is least capacity to bear it, in those industries, as it happens, which are most essential to the country's prosperity. In the case of the sheltered occupations little inconvenience may arise; the burden may be borne or passed on. But in the case of the unsheltered industries, where the full rigour of foreign competition has already produced a position of grave embarrassment reflected in the unemployment returns, it is not permissible to regard the burden of social insurance as negligible and free from possible detrimental reactions on the prosperity of the country and indeed on the employment of the worker.

4. Apart from these two questions there are, further, three matters of general principle, in certain respects inter-related, on which, as it appears to us, not a little misapprehension prevails. We should like the following observations on these questions to be read not merely as supplementing, but perhaps to a certain limited extent as modifying, our concurrence in the terms of the Report signed by our colleagues.

5. It is sometimes argued that money spent on health services will result in savings later, that, as one witness put it, it will yield dividends. In one sense this is obviously true so far as the individual is concerned, but at times the contention appears to involve an unwarrantable implication. By those who argue in favour of more extended expenditure on health services, it is sometimes suggested that this would in no wise diminish—but might on the contrary increase—the power of the country to bear the weight of its financial embarrassments; that there is in any case a burden of ill-health and suffering to be borne, which is capable of being expressed in terms of money, and that the removal of this would have a favourable influence on the prosperity and the financial condition of the country. "The burden, the ill-health, the loss in wage, the expenditure on medical service, these" we are told "are already with us. Insurance is a device for shifting or transferring the financing of the burden." That health is financially an asset is undeniable, whether from the point of view of the individual or of the State. Nevertheless if it is suggested that expenditure on health services will render it an easier matter for the community to bear the financial burden resting upon it, the argument is, we think, specious. Expenditure on social services is not infrequently supported by reference to the economies which will elsewhere result; it is difficult, viewing the matter retrospectively, to find instances where such hopes have been adequately realised. As our health services are at present organised, we see little to support the view that expenditure on health now would lead to a diminution of expenditure on health in the future. On the contrary, there are grounds for believing that expenditure on health, unless primarily directed to the removal of the causes of ill-health, may tend to occasion a further increase in such expenditure. These observations are not to be taken as implying that there is not a strong case for expenditure on health services or even that a case might not be made out for regarding such expenditure as so urgent as to constitute the first call on the country's resources. With that particular question we are not at the moment concerned. We merely desire to point out that the case for expenditure on health is not in fact furthered by what, we are convinced, is the fallacious suggestion that expenditure on health may indirectly help to rehabilitate the finances of the country.

6. It is implicit in the contentions of many witnesses that all the medical resources of the country should be made available for every insured person, and obviously, in so far as it should prove to be practicable, the desirability of giving effect to such an ideal (which on general principles need not be restricted to medical resources nor to insured persons) would be denied by none. We are not discussing the argument for the widest possible extension of medical benefit or for the extension of other

benefits in various circumstances of need where such assistance may be desirable. We are merely concerned to point out that beyond a certain point such claims may become inconsistent with the arrangements under which society is at present created and continued. Even the State cannot accept, since in certain contingencies it might not be able to meet, an undefined liability, and it follows that in theory the State can only assume full responsibility for the maintenance of all within its borders, if simultaneously there is conceded to it a greater power of control over the constitution of society from generation to generation than has ever before been considered either desirable or practicable. If the State is to be a generally beneficent organisation, it can only be on the assumption that it has previously sanctioned the existence of those whose claims it is bound to honour. For such an assumption there is at present no warrant, and it may with reason be contended that unrestrained freedom in the individual to beget life, and communal responsibility for the maintenance of life, are ultimately incompatible. As before, we are arguing neither for one side nor the other; we are merely concerned to point out that certain current ideals which have coloured much of the evidence put before us, are inconsistent with the general structure of society.

7. On a review of the evidence we cannot but feel that there is considerable confusion in certain quarters with regard to the relation which exists between the care of the individual's health and the wider question of the promotion of the health of the community. Obviously the medical profession can give curative treatment to individuals alone; obviously also a community in which every individual is healthy will be a healthy community. It seems in consequence to be frequently assumed that by merely attending to the health of individuals, a healthy population will finally emerge. We believe this to be a profound error, and we are glad to be able to cite the evidence of the British Medical Association that the organisation of a National Health Insurance Scheme (which primarily relies on giving medical benefit to individuals) is not even probably the best means of utilising limited resources for the promotion of national health. We are also glad to be able to quote their view that " the alleviation or cure of morbid conditions when once they have arisen " is, relatively to other matters, a minor part in the campaign for public health. It is perhaps not reading too much into the evidence of the British Medical Association to suggest that they would not dissent from the view that the function of the practising doctor in raising the general health of the nation to a higher level is, from a certain aspect, less important than is sometimes assumed. In the case of the large volume of ill-health which is ultimately due to environment or occupation, the doctor may from time to time cure the individual. But ill-health will remain if the causes of ill-health remain, and the fundamental problem

here is not, strictly speaking, a medical one. Ultimate victory may come from the sanitary side of medical science. In other cases where the individual is cured the cause of public health may, or may not, be promoted. " Postponement of the event of death," which is sometimes cited as proving an advance in public health, may in fact tend in the opposite direction. We do not here refer to one factor, obvious although frequently overlooked, in which medical attendance, even while improving the health of the community, must tend towards an increase in the actual volume of sickness. Every one who is sick and recovers lives to be sick later on, and prolongation of life means, among other things, that in the age distribution of the population, a larger proportion fall within those groups which are more exposed to the risk of illness. Without considering remoter consequences, " postponement of the event of death " may therefore mean, in many cases must mean, an increase in the number of illnesses requiring medical attention.

8. In this possible direct increase in the volume of sickness, there is, however, nothing to cause perturbation from the point of view of public health, but it is different when we turn to consider the possibility of those remoter consequences which do in fact exist. Apart from occasional and fortuitous illnesses which may befall the healthiest, and those due to environment, it is a matter of common knowledge that a large volume of illness is due to constitutional predisposition and to a diminished power of resistance which is an inalienable part of the sufferer's equipment for life. There are many of whom it can be predicted even before birth that they will probably be ill for the greater part of such life as may be granted to them, and perhaps even the nature of the illness from which they may be expected to suffer—unless in the interval medical science has made notable advances—can be broadly foretold. Clearly when those who have a lessened immunity from disease are enabled, as a result of the postponement of the event of death, to leave behind them heirs to their weaknesses, the general cause of public health will in many cases have been frustrated and not promoted by the medical attention which they have received. In such matters it is difficult to obtain strict proof one way or the other, but when we are inclined to be complacent over the postponement of the event of death, we should remember that there is at least a *prima facie* possibility that over a considerable part of the field, the application of medical science—however immediately advantageous to the individual—may not in its ultimate results be wholly free from certain consequences disadvantageous to the community at large. It is the honourable and charitable foundation of the medical profession that suffering, wherever it exists, is to be relieved; that life, so long as it may be, is to be strengthened and continued, even if the doctor may be convinced in his mind that it is being strengthened only to meet years of labour and sorrow.

Nor would any one suggest that the medical profession could properly do its work on any other basis than that of regarding the health and the recovery of each patient as being at the moment the one supreme and only consideration. Yet clearly there may here be, as things are at present, a possibility of conflict between the ultimate ideals of the medical profession, which regards every individual life as alike of supreme importance, and the remoter interests of the community, which in retrospect may not be able to take so impartial a view; for while it is the aim and object of medical attendance to strive to the uttermost to keep alive even the most unfit, it may incidentally, and as a consequence, give these the opportunity of continuing their race in the next generation. It would be as well to realise that this is a force which is certainly operative to some extent, and may be operative to a considerable extent, and in so far as it is so operative, and unless counteracted by other influences (as it might be *e.g.*, by the advance of medical science) it will tend to a continual worsening of the health of the population generally and a continually increasing drain for health services.

9. While attaching little importance to the figures, which are capable of many partial explanations, it is perhaps significant and worthy of parenthetical observation that recent years have been characterised by (1) a falling death-rate, (2) an increase of disablement benefit, (3) an increase in the frequency of prescriptions.

10. Although notable results have been, and will be, achieved by the machinery now in operation, these considerations raise doubts as to the possibility, on present lines, of attaining such a measure of ultimate success as some consider capable of achievement. The overlapping of our health authorities and the lack of co-ordination between their efforts have been the subject of much criticism, and much constructive thought has been directed towards the creation of the perfect local authority which shall assert an effective leadership in the re-establishment of the public health. Doubtless these criticisms are justified and such suggestions as have been made are all to the good and, if adopted, will promote economy and administrative efficiency. Yet we cannot help feeling that the mere manipulation of local government machinery, important as it may be, may not in itself take us as far as is sometimes suggested.

11. On a review of the public machinery for promoting health, the conclusion is forced on us that the entrance by which a not inconsiderable part of illness finds its way into the community is seldom even discussed, and further that the increasing excellence of our medical machinery may enable an enlarged volume of sickness to enter by this doorway.

12. Apart from emphasising the time-honoured truth that it is better to prevent the existence of disease than to cure it when it has emerged, we do not, however, think that the time is appropriate even for an adumbration of the practical conclusions to which these considerations might lead. The problem, which should not be impracticable of solution, is to devise a method whereby society, while guaranteeing to every individual the opportunity of a reasonably complete life, shall yet be able to protect itself against the infusion of elements calculated to be a source of weakness. So far from the conjoint attainment of these two ends being impracticable, it may be suggested that the first and more visionary is possible of achievement only on condition that the second and less popular is in some measure realised. We have ventured to submit these observations, not with the object of making concrete suggestions, but rather in order to discourage an easy and prevalent optimism which lightly overleaps the limits of the practical and attainable, and also in the hope that those who are impressed by the inadequacy of our national efforts on the health side may be led to seek for a deeper cause and so prepare the way for a more fruitful discussion of these matters.

(Signed) ANDREW R. DUNCAN.
ALEXANDER GRAY.

MINORITY REPORT.

May it Please Your Majesty,

1. We regret that we have not found ourselves able to accept those conclusions of the majority of Your Commissioners which, in our view, deal with the really essential problems of the Scheme of National Health Insurance, and we therefore crave leave to present separately our own views on these matters.

General.

2. The recommendations contained in the Majority Report may be considered in two parts, namely, those designed to improve details under whatever system National Health Insurance is administered, and those designed to secure improvements within the present system and within the present financial limits of the Scheme. With regard to the first part, we are in agreement with our colleagues except as to those matters to which we shall refer later, and with regard to the second part, we agree that in the main the recommendations will effect improvements upon the existing system and within the present financial limits. We shall, however, refer later to certain recommendations which we feel will be of doubtful value.

3. The main questions of principle on which we differ from our colleagues are as follows :—

(1) The evidence which we, in common with them, have heard, convinces us that it is undesirable to retain Approved Societies any longer as the agencies through which benefits paid in cash are distributed to insured persons : and

(2) we do not accept the view that it is either necessary or proper to assume that we are to recommend no development intended to provide, in the words of the Act of 1911, "for insurance against loss of health, and for the prevention and cure of sickness," which cannot be paid for out of the produce of the contributory scheme of Health Insurance as it stands; and we feel it our duty to make recommendations in favour of :—

(*a*) The provision of medical treatment and attendance for :—

(i) children of school-leaving age; and

(ii) dependants of insured persons;

(*b*) Extended provision for child-bearing women before, at, and after confinement;

(*c*) Increase of the rates of benefits paid in cash under the National Health Insurance Acts to the present rates under the Unemployment Insurance Acts.

Approved Societies.

4. We are in fullest agreement with those statements in the Majority Report which lay stress on the need for linking-up all medical services under Local Authorities, i.e., the County, Town or District Councils. We believe that the only way to deal effectively with the health of the community is by doing away with the overlapping of Authorities, and that efficiency and economy must result from changes which, in the words of a circular recently issued by the Minister of Health are "directed to securing as close as possible an approach to the position that a single Local Authority shall be wholly or mainly responsible for the local administration of its area and co-incidentally for viewing as a whole the finances of local government in the area." This principle has been so cogently argued in the Majority Report, that it is unnecessary for us to labour it, but we are unable to find any good reason for making an exception to it in favour of that part of the system of provision for health services which is at present administered by Approved Societies.

5. Until that part of the system is taken out of the hands of Approved Societies and placed in the hands of Local Authorities, we hold that the policy which received the general support of our colleagues, and is being urged by the Minister of Health in application to services at present administered by Boards of Guardians, cannot be applied to its full and proper extent.

6. We take this view because, first, we think that in essence the administration of benefits paid in cash under the National Health Insurance Acts is a health service. These payments are made either

(1) When a woman within the present scope of maternity benefit is confined of a child; or

(2) When an insured person becomes and remains incapable of work owing to illness; or

(3) When an insured person who happens to belong to a Society which can provide additional benefits, can show that a payment enabling him to get one of these benefits would be likely to improve his health.

7. If the function of the Approved Society in relation to these types of payment is examined, it will be seen to be as follows:—

(1) The interest of the Approved Society in the child-bearing woman begins and ends with handing over to her a lump sum of money. That Local Authorities could make this payment equally well is self-evident. It is scarcely less obvious that much more could be done for child-bearing women who need other services directed to safeguarding the health of mothers and infants by Local Authorities, who already administer such services, than by Approved Societies, who have nothing to do with them.

(2) The interest of the Approved Society in the normal and the additional benefits is less narrow. In relation to the normal benefits they are concerned (*a*) to see that insured persons who are entitled to benefit are promptly paid, and (*b*) to see that no insured person is paid unless he is entitled to payment.

Local Authorities, who deal with people living in their respective areas, could of course pay benefit in proper cases at least as quickly as Approved Societies, whose members may live in any one of the administrative areas of the country.

Whether a payment ought to be made to an insured person depends upon the answer to the question, "Is this person incapable of work owing to illness?" This question is answered, in practice, by a doctor, subject to the right of the body through whom payment is made to scrutinise the doctor's certificate, to obtain a further medical opinion, and to complain if they think that the doctor has not told the truth.

Now it seems to us that the whole of these proceedings are an integral part of the medical service rendered by insurance practitioners under their contracts.

The Commission are unanimous in recommending that Insurance Committees should be abolished and that their functions should be transferred to Local Authorities, and we cannot resist the further conclusion that Local Authorities could and should take the place of Approved Societies as the Authorities through whom sickness and disablement benefits should be administered.

(3) In relation to the payment of sums enabling an insured person to get an additional benefit:—

(*a*) so far as the additional benefits consist in increases of the normal benefits, the Approved Society is concerned with the points already dealt with;

(*b*) so far as the additional benefits are in the nature of medical benefit, the interest of the Approved Society is, or (as our colleagues agree) ought to be, no more extensive. They do not provide the benefits. They merely hand over to some of their members, who, if properly selected, are so selected on medical grounds, money enabling the benefits to be obtained. They are not qualified to assess the value of the services rendered for the money, and we gather that the business of securing a proper return for the sums spent on dental and ophthalmic treatment given by way of additional benefit is, in fact, receiving the attention of the Minister of Health.

We are convinced that the whole of this work, so far as it is a matter of local administration, could be far better done by the Local Authorities already responsible for other health services.

8. Secondly, we do not think that the administration of benefits paid in cash, being a health service, is a health service which it is desirable to administer through agencies specially constituted for the purposes of this service alone.

9. In support of this view we would submit four arguments, one based upon considerations of general policy, and three upon the practical consequences of these considerations.

10. The first is that the citizenship of insured persons is more important than their insurability. Just as Your Majesty's Government refuse to accept the argument of Boards of Guardians that separate authorities ought to deal with citizens who happen to be destitute, so we hold that any attachment which insured persons may have to their Approved Societies can and should be transferred, with the work of the Societies, to the Local Authorities of the areas in which they live.

11. The second argument is that the result of this transfer would be to remove the scandal, admitted by our colleagues, that Approved Societies comprising a very large part of the total insured population are administered with complete disregard of the direction of Parliament contained in Section 23 of the Act of 1911 that their affairs should be subject to the absolute control of their members.

12. The Majority Report seems to us to evade that issue in the statement that most people do not "maintain that degree of interest in public affairs which good citizenship postulates."

13. The fact is that the constitution of the Approved Societies to which we have referred, makes it impossible for the members to take any substantial part in the management.

14. The local government franchise at least makes it possible for all electors to develop and manifest a proper concern in local administration.

15. The lesson of events, as Your Majesty's Government recognise in relation to Boards of Guardians, is that the way to encourage citizens, including insured persons, to face their responsibilities and protect their pockets, is to reduce the number of bodies on whose proceedings they are called upon to pass judgment, and to concentrate in the hands of the Local Authorities already charged with most of the business which affects insured persons' lives, the residue of the powers which can and should be locally exercised.

16. The third argument is that the transfer to Local Authorities of the administration of benefits paid in cash would result in a greater equalisation of liabilities over the insured population as a whole than is secured under the present system. The present association of insured persons in Approved Societies is inimical to the interest of those persons as a whole, and to the interest of employers and taxpayers who contribute to the cost of the system, because in practice it encourages the process by which the members composing the healthy groups get most (by way of additional benefits) in return for their contributions, and the least healthy least. Under the Approved Society System it is, in our opinion, impossible to use the whole resources of National Health Insurance to the greatest advantage of the insured population as a whole.

17. The object of a " national " health insurance system must presumably be, not to supply cream to the fat and skim milk to the lean, but good milk to all insured persons.

18. It is already an accepted doctrine of local government that the inhabitants of a given town or county have such community of interest with each other that those who are able can properly be called upon to pay for services which others need. A system based upon the historic administrative areas of the country has, therefore, the indefinable but important advantage of enlisting the support of local sentiment and local patriotism.

19. Where the local community of interest in a public service stops, and the interest of the community as a whole in the efficiency of the service begins, that fact is recognised by the payment of a contribution by the taxpayer in aid of the cost of the service.

20. The fourth argument is that the transfer of the work of Approved Societies to Local Authorities must, if it had any effect of this kind at all, improve and not weaken the possibility of putting into operation the provisions of the Act of 1911 which were designed to enable the burden of cost resulting from excessive sickness (that is, sickness which could and should have been prevented) to be put upon the right shoulders.

21. It is clear from Sections 15 (7), 22 and 63 of the Act of 1911 (now Sections 85 and 107 of the 1924 Consolidating Act), and from the statements made in Parliament on the introduction of the Bill, that the framers of the measure intended their scheme to be intimately connected with the other health services, and enquiry and action were to be possible wherever bad environment induced ill-health. Thus action could be taken wherever the conditions or nature of employment, bad housing or sanitation, insufficient water supply, or, indeed, neglect on the part of any person or Authority to enforce the law relating to public health or housing was involved.

22. Yet Section 107 is a dead letter, and that this is so is largely due to the fact that membership of Approved Societies is scattered all over the kingdom instead of being localised, and that in one street, or indeed in one house, every inhabitant may belong to a different Society, each with its headquarters entirely out of reach of the ordinary insured member.

23. This brings us to another essential point laid down by the framers of the Act. The scheme was to be democratic, controlled by the insured for the insured. Here again the Act is almost a dead letter, and we feel that in this case also the constitution of the Societies renders it inoperative.

24. The statement of our colleagues that most people do not "maintain that degree of interest in public affairs which good citizenship postulates" is of general philosophic interest, but it appears to us to have no bearing on the question before us. In every class of life people are interested in matters which affect their pockets, and the fact that insured members are not interested in the management of a scheme which involves deductions from their wages and accruing benefits, suggests something very wrong with the machinery. We believe that different results might be achieved if these Societies came under the control of the Local Authority. This would limit their numbers to about 150 Societies as against 7,876 existing financial units. The best officers already trained in Approved Society work would be available and the varying occupational risks which at present aggravate inequalities would be modified by territorial grouping.

The Approved Society System.

25. We have reviewed the system of Approved Societies in order to ascertain on the one hand whether it has fulfilled the intentions of Parliament, and on the other hand, whether it is the most effective method of administering a scheme so closely related to public health in all its phases.

26. With regard to the first part we are definitely of the opinion that the wide disparity in valuation results was not contemplated by Parliament, and that the complete lack of any real opportunity for membership control, affecting over half the insured population, has rendered almost negligible a feature of the system to which Parliament attached very great importance.

27. The views adduced that in general the free choice of Society disposes of any suggestion of hardship upon the members of Societies with no surplus, does not in our judgment dispose of the matter. Nor do we agree that this segregation of the insured population into Societies is an essential part of a scheme which some witnesses consider embodies a "true insurance principle."

28. We are aware that the generous estimate of the liabilities of the Act which has hitherto formed the actuarial basis, has been

responsible for the immense surpluses which Societies are now distributing in the form of additional benefits, and that the disparity in valuation results would have been the same if either the expenditure had been heavier in the aggregate or the actuarial estimate had been less generous.

29. In either of the latter events, however, the statutory or normal rate of benefits of the Act would have been jeopardised to such an extent and for so large a proportion of the population as to have created a problem with which Parliament must have been compelled to deal.

30. So long as nearly every Society is able to maintain or increase the normal rates of benefit the disparities do not get the attention they otherwise would.

31. The Departmental Actuarial Committee state in para. 5 of their First Report "It is clear . . . that Parliament intended the scheme to be solvent, regarded as a whole, whatever might follow from the grouping of risks incidental to the voluntary segregation of insured persons in Approved Societies," and it is further reported that the new actuarial basis referred to in the Report, "will be that which, so far as we can estimate, would be required if the whole system were operated through a common fund."

32. We think that these two quotations point to an intention of greater uniformity in the scale of benefits than has been in fact realised and we feel sure that Parliament could not have foreseen that over the whole insured population there would be a surplus of 40 to 45 million pounds, nor that the segregation of insured persons would produce such wide disparities.

33. We agree that on the whole the administration by Approved Societies has been of a high standard and that many of the grounds for criticism are due to the weakness of the system and not to any incapacity upon the part of the officers of the Societies. At the same time we are compelled to say that there are no methods of judging the real standard of efficiency of Societies. A standard which passes the Treasury auditors is a criterion only as to accuracy in accounting and in a lesser degree as to the legal accuracy of the work done. There is no test, other than that made in individual cases in which complaint is made to the Minister, as to whether benefit is paid to every member who is properly entitled to it. An auditor may discover an irregular payment, but he cannot discover an irregular non-payment.

34. We are led to draw attention to this by the often-repeated statement that the Approved Society system provides an incentive to good management. If such an incentive exists we fear that its product must be stringent management against which no system

of audit or of inspection or of appeal in the case of disputes is a sufficient safeguard for the insured person.

35. We agree also with our colleagues that evidence from insured persons themselves would have been desirable and we recognise the difficulties mentioned. Our anxiety in this respect is not lessened by the observations accompanying the recommendations in the Majority Report that the Department needs further disciplinary powers to ensure higher efficiency, and more particularly with para. 242 of the Report. We also attach much importance to the observations in the Memorandum appended to the First Report of the Departmental Actuarial Committee, para. 13, "it . . . . seems to suggest that Societies are applying to the disablement claims of married women a degree of activity that might well be exerted, and at an earlier stage, on all claims of prolonged duration." Further significant passages on this subject appear in para. 18 of the same Memorandum.

36. In the absence of evidence from insured persons themselves we attach the greatest importance to the foregoing indications of features which must operate against the interests of insured persons as a whole and must give rise to grave injustice to individuals and classes who, so far as can be judged, most need the benefit of the Act.

37. The tables of expectation of sickness and disablement benefits are not sacrosant, and we see little virtue in them in relation to a standard of administration. The real standard of administration is not merely that insured persons should be restrained from receiving benefits improperly, but also, and perhaps of greater importance, that insured persons incapable of work should always get the cash benefits to which they are entitled. If "experience" belies "expectation," means other than drastic administration must be sought to right matters.

Control of Societies by their Members.

38. We have definitely come to the conclusion that the vast majority of insured persons take no interest whatever in the affairs of the Societies and that probably two-thirds of the insured population cannot exercise any real control in their Societies. The constitution and government of the Friendly Societies and Trade Unions, and of certain of the smaller centralised or localised Societies provide the opportunity for members to exercise their will; but the volume of evidence shows that insured persons as such have not exercised, and are not exercising, any real control. In those Societies, where the development of the "fraternal spirit" was expected, it is admitted that the insured members "take no real interest in the work." (*Heather*, Q. 5523,5616). In the case of the large Industrial Companies it is not pretended that membership control is

possible (*Neill*, Q. 4442). " . . . . it is simply that the machinery is not there." (*Kinnear*, Q. 23,576.)

39. In general the evidence proves conclusively that membership control " is largely theoretical " (*Kinnear*, Q. 578) and that " as a general rule the great majority of insured persons take little or no interest in the government of their Society." (*Kinnear*, Q. 515; see also *Brock*, Q. 959). The number of members necessary to form a quorum at a General Meeting of a Society, given in Table 3, and the following paragraphs of the evidence of the Department (Section B of Appendix I) emphasises the absurdity of the so-called " membership control " :—

> " 23. It will be seen that at one end of the scale, eight members constitute a quorum in the case of the Mayfield Temperance Friendly Society (Approval No. 1274) a small local Society, consisting of 48 members. Yet even this restricted quorum could not be obtained in 1922. At the other end of the scale is the Liverpool Victoria Approved Society (Approval No. 119) which, with nearly half a million members, is required by its rules to have a quorum of 12, whether insured persons or not, including any officers and members of the committee present, who themselves number eight.
>
> 24. Similarly with the large industrial Approved Societies, such as the National Amalgamated (Approval No. 125) and the Prudential Societies (Approval Nos. 136 and 137). The former has over two million members, and the requisite quorum is 50 in England, and 20 in Scotland, including the officers and Committee men, who themselves number about 20.
>
> The rules of the two large Prudential Societies each with over one million members, also provide that 50 members, including any officers and members of the Committee present, shall form a quorum."

40. This, considered together with the evidence given on this subject by representatives of the Industrial Societies (Q. 4515-4529, 4568-4743), leads us to the conclusion that the intentions of Parliament in this respect have not been fulfilled.

The Incentive to Good Management.

41. We have shown that the members as such are not interested in the management of their Societies, but it is claimed that the officers are able so to develop their system of administration as to exercise a vital influence upon valuation results.

42. We agree with our colleagues that the effect of this incentive upon the valuation results is grossly exaggerated, and that other factors, occupational and otherwise, are the predominating causes of the great disparities in the surpluses declared.

43. We submit that in so far as the incentive does exist it is inimical to the improvement of the standard of national health. In the main it only manifests itself in two ways: (1) by a judicious selection of good lives, and (2) by a reduction of expenditure on benefits.

44. The absence of control by the insured persons is, in itself, to be deplored in a public scheme, but when it is remembered that the close interest of the members in the work of their Societies was designed to produce an incentive to efficient administration it will be realised that its absence assumes much greater importance.

45. It has been claimed by many Society witnesses—and in certain parts of the Majority Report our colleagues appear to support the claim—that this incentive is a necessary and desirable feature of National Health Insurance. We propose therefore to examine the contention further.

46. As we understand it, the theory is that the members of each Society would interest themselves in the management of the Society with a view to conserving the funds in order to produce a surplus at a valuation.

47. The practice of rejecting applicants for membership who are thought to bring an abnormal risk means segregation of all good lives from all bad lives, with the consequent breakdown of the preventive and curative objects of the Act for those sections of the community which need them most. "If by economical management is meant the exclusion by medical examination of those likely to be a charge upon Societies . . . . then the Union sees little virtue in it" (*Medical Practitioners' Union*, App. XLVIII, 18, i).

48. There is no doubt that witnesses have considered the main effect of the incentive to be the safeguarding of the funds against what they considered to be undue claims, and it is mostly in this respect that it has been effective. If the scheme were administered through a system which contained an element of uniformity the operation of such an incentive would be less undesirable, but when it is remembered that there is an almost complete absence of uniformity from the issue of a medical certificate to the payment of the benefit, the effect of an incentive with the purpose of economising on benefits is definitely vicious. Saving the funds by curtailing the benefits of the sick persons and forcing them back to work or otherwise leaving them to starve, is not a feature that is either economical in the long run, or moral in a State scheme, but that it is present there is no doubt whatever. "Some of the Societies are inclined to apply too rigid a test when the alarming question of disablement benefit comes to their notice." (*Kinnear*, Q.313.)

49. We consider it a fallacy to conclude that a high surplus at a valuation means good administration and that a deficiency provides a *primâ facie* case of bad administration. We think, on the contrary, that in general the Society with the heavier expenditure will be more likely to be actuated by the "incentive," as it is generally understood, than the Society in which the expenditure is low. As an illustration: a Society carrying the hazardous risks of the miners being in deficit at a valuation would require to prove that its standard of administration was of a high order before it could make a claim upon the Central Fund, whereas a Society composed of healthy lives could afford to, and would, undoubtedly, be less strict upon its members.

50. The only evidence of an incentive alleged to operate in a direction consistent with the objects of the Act was given by a representative of Employers' Provident Funds, who claimed that in order to reduce the expenditure on benefits the employers sought to improve working conditions. (*Lesser*, Q. 13,375.)

Valuation Results.

51. The large surpluses and the disparities in those surpluses have been referred to at length in the Majority Report, and certain developments and modifications designed to reduce the surpluses and to some extent the disparities are there recommended.

52. We are of the opinion that the effect of extending the statutory benefits to absorb the moneys released by the new actuarial basis recommended by the Actuarial Committee will create a serious position for those Societies which, on the present financial basis, have little or no surplus. The operation of the Central Fund and the partial pooling of surpluses will probably enable all Societies to continue to provide the normal rates of benefits, but unless the equalising operations precede the valuation reports the position of certain Societies will still appear quite hopeless. We agree that "no Society and no type of Society can claim a prescriptive right to a guaranteed existence," but we think it proper to say that the gradual decrease in the membership of Societies below the average financial standard will ultimately compel their decease and that the only Societies which could afford to accept a transfer of engagements of such a Society are the largest, which are just those where membership control can be least effective.

53. The emergence of surpluses and the consequent provision of additional benefits have emphasised the weakness of the system when viewed from the standpoint of the prevention and cure of sickness. It will be obvious that a Society is only able to provide additional benefits in proportion to the standard of

health of its membership. If it is composed of extremely healthy members it can, by providing a wide range of additional benefits, many of a medical character, enable them to become still more healthy. If, on the other hand, it is composed of members whose standard of health is below the average, or who may be engaged in hazardous occupations, or occupations which call for a higher degree of physical strength than others, the current expenditure on cash benefits leaves no margin for surplus, and, as a consequence, that section of the community who need all possible services of a preventive and curative character are limited strictly to the bare statutory benefits of the Act. As we have been told, the position of such a member is as follows:— " . . . . the Act goes on providing him with medical treatment necessary for dealing with the consequences of his defective teeth, but unless he happens to be in a Society which has some sort of dental benefit . . . . nothing whatever is done for his teeth." (*Brock*, Q. 1,080.)

Hindrance to Development.

54. We consider that the Approved Society system in itself militates against a variety of developments which might be found desirable. Evidence was given to show (1) that the extension of cash benefits to dependants would accentuate the present deviation from the general average which results from the system of insurance through Approved Societies (Second Report of the Actuarial Committee and *Kinnear*, Q. 23,460) and (2) that "it would not be practicable for Approved Societies organised on their present lines to administer Workmen's Compensation" (*Kinnear*, Q. 23,461). The Friendly Society Movement was unanimous in desiring the limitation of cash benefits, notwithstanding that the present rates were admittedly insufficient (*National Conference of Friendly Societies*, Q. 10,649-10,679; *Heather*, Q. 5590.) "It may be thought that that answer is prompted by selfish motives, or by a desire to protect an existing vested interest. If that is so I plead guilty to that quite frankly (*Duff*, Q. 4,070); and again, "We are advocating that nothing shall be done which will injure the Friendly Societies." (*Shaw*, Q. 10,725.)

55. The Friendly Societies submit that they give an opportunity to the insured population to insure themselves privately, and urge that it is desirable that personal thrift should be encouraged. We express no opinion on this latter point, but it is important to note that the representative of one of the largest Orders agreed that "as regards a very large proportion of seven million people, State Insurance is the only form of insurance they can hope to get." (*Heather*, Q. 5,608.) The system is a hindrance to the development of a complete Public Health policy, inasmuch as it is primarily concerned with the distribu-

tion of cash benefits without the slightest relationship to public activities affecting the need for these benefits.

56. We accept the principle laid down by the Majority Report as to " the desirability of bringing into closer relationship the various services directed towards the prevention of sickness and the improvement of health." We submit that this is impossible while one essential health service is left unattached; and we recommend the substitution of Societies under appropriate Local Authorities, which would apparently be the County Councils and County Borough Councils, for the present system of Approved Societies.

57. It seems to us that substantially each of these groups would be fairly representative of the industrial population of the country, but in so far as they were not equally representative the operation of a Central Fund might be the means of equalisation.

58. At the outset, for the purpose of securing essential statistics and in order to determine the standards of health in different parts of the country, it may be necessary to consider each group as an area Society, the Society operating financially very similarly to an Approved Society under the present system; but as time and experience allowed, it is not unreasonable to suppose that the actuarial basis as we know it, and the valuations as they are now conducted, could be very materially modified. We should, then, for the purpose of establishing this new system, proceed along existing actuarial lines.

The Finances of the Present Scheme.

59. We are unable to agree that we should make no recommendation which takes us outside the financial limits of the present scheme. We submit that there is financial loss due to the overlapping of the various services at present in operation and that the money available will be increased when these services are unified and controlled under the Local Authority.

60. We are also clear that a Commission dealing with National Health Insurance must take into account national loss resulting from neglect to provide sufficiently for the health of all those who are or will be employable.

61. The whole question of national health is bound up with that of efficiency and output, and it is impossible to rank as a " burden " on industry or on the community an outlay which safeguards industrial well-being and (to put it no higher) conduces to the efficiency of the machine. These charges produce a definite return. " There is five per cent. in good conditions," said a great employer of labour.

62. We agree with our colleagues that it is desirable " that a balance between the expenditure on these schemes

and the productive capacity of the country should from time to time be struck, even though this can probably be done only in a very general way and without reduction to any precise formula." But since everything which impairs efficiency reduces that productive capacity, the final balance will not be realised till we have carried all our social services to perfection. Our recommendations at this moment are, however, confined to those which appear to us urgently necessary, and immediately practicable.

63. Social services, as has been well shown in the Majority Report, are financed from various sources. The State, the Local Authority, and various systems of insurance supply the funds, and it is impossible to draw a hard-and-fast line between the services to which we should contribute as taxpayers or ratepayers, or as employers and employed persons. We do not subscribe to the distinction drawn between social services conducted in the interest of the individual, and similar services conducted for the general well-being of the community, since the "well-being of the community" is involved in all. In this connexion we feel that there is cogency in the representations made to us, that the contributions of employer and employed to National Health Insurance should alike be reduced and the State's contribution proportionately increased (*National Confederation of Employers' Organisations*, App. CVII, 28). The salient fact is that for every deficiency in our social services, someone pays. We can alter the incidence of payment, and treat our obligations as matters to be supplemented by the Poor Law, or by voluntary aid, but the only case in which we pay without return is in support of the disabled, who could by larger preventive outlay have given us the return of efficient healthy labour. While we feel that our present methods of conducting our social services are expensive and over-lapping, and that real economies are to be effected from their unification, we also feel that any further moneys needed for the services indicated below will go far to relieve us of the "burdens" (properly so-called) described by Sir George Newman and the accredited officers of the Ministry of Health.

Medical Benefit.

64. We support the recommendations of the Majority Report to extend the scope of medical benefit, but it should be noted that Parliamentary grants were voted in 1914 for services, the development of some of which has not been undertaken owing to War conditions. Such services included :—

(1) Medical referees.

(2) Medical experts from whom second opinions could be obtained by medical referees.

(3) General practitioner clinics.
(4) Laboratory services.
(5) Nursing for insured persons.
(6) Health lectures. (App. CIII.)

65. In our view the extension proposed will still leave out of medical benefit services which the evidence has shown would tend both to prevent sickness and to effect a speedier and more complete cure of the insured person.

66. As both these results are not only desirable in themselves, but would be accompanied by economy of expenditure on cash benefits, we submit that the provision of a complete medical and treatment service should not depend for its financing entirely upon current contributions. We agree with our colleagues that " considering the beneficial results on the health of the insured community which ought to follow from the medical service provided by the Act . . . . it is not unreasonable to look for improved conditions so far as the claims are concerned." (para. 177.)

67. The experience of administering the insurance medical service gained since 1912, which has made practicable many desirable developments impossible at the inception of the Scheme, should enable an estimate to be made of the future effect of a considerable extension of that service upon expenditure on cash benefits. In other words, the loading for actuarial safety of the cost of cash benefits should be affected by the kind and extent of preventive and curative services available for the insured population. The following extract from the evidence affords an example in relation to dental benefit merely. " . . . . I think the experience of those Societies that have provided dental treatment . . . . does give ground for hoping that systematic dental treatment would lead ultimately to a reduction of sickness benefit claims . . . ." (*Brock*, Q. 23,914.)

68. The National Conference of Friendly Societies (App. XXVI), the National Association of Trade Union Approved Societies (App. XCII), the British Medical Association (App. XLVII, 20) and other organisations are unanimous in advocating great extensions of medical benefit.

69. As to the desirability of including dental advice and treatment within the range of medical benefit, it was stated by a Departmental witness that " something like three-quarters of the industrial population probably are suffering from dental defects of one sort of another." (*Brock*, Q. 23,914.)

70. We therefore recommend that medical benefit, extended as recommended in the Majority Report, should be further

extended to include attendance at confinement and dental and ophthalmic advice and treatment.

Medical Benefit for Dependants.

71. The great weight of evidence from Approved Societies and from medical and other professional organisations was in favour of the extension of medical benefit to dependants.

72. Witnesses representing many diverse interests expressed the view that if the provision of medical services to the dependants of insured persons is desirable then the absence of those services is a cost to the nation in one form or another. But even considered from the narrower standpoint of National Insurance, we submit that the future value of present expenditure upon medical and treatment services to children and mothers of children may be taken into account in estimating the future liabilities of the Scheme. We, therefore, submit that medical benefit should be provided for the dependants of insured persons.

Cost of Medical Benefit.

73. The expense of a national system of medical services is difficult to estimate, but we submit that it is a fallacy to count all expenditure as cost. The state of the health of the people, young and old, is such as to be of incalculable loss to the nation, and a well-organised, comprehensive scheme must diminish the loss with increasing force.

74. The linking-up of the contemplated medical services with other public medical services would in itself effect direct economies in administration, and as experience dictated, further economies would follow.

75. We therefore look upon the expenditure on this service, not as a cost, but largely as a new channel through which existing expenditure is to be diverted, with the difference that the new channel is ordered and directed to the prevention of sickness, whereas the old method is wasteful, fortuitous, and frequently comes into operation too late to be effective.

76. At this point it will be convenient to refer to the recommendation in the Majority Report that the first call on the margin in the contributions resulting from the proposals of the Departmental Actuarial Committee must be the balance of the cost of the present medical benefit (para. 182).

77. Paras. 130 to 142 of Section C of Appendix I to the Minutes of Evidence review the various modifications in the rates of payment for medical treatment from 1912 to the present time. In that review it is seen that the original estimate of the cost of medical benefit was 6*s*. per head per year and that this amount was supplemented by an Exchequer grant of 2*s*. 6*d*. per head

which, with 6*d.* added in respect of the domiciliary treatment of Tuberculosis, made available a sum of 9*s.* per head per annum for medical benefit. An Exchequer grant in respect of medical benefit continued until the 31st March, 1922, since when the cost of medical benefit has been met from insurance funds, including the statutory State grant of two-ninths of the cost. This change was made in pursuance of a recommendation of the Committee on National Economy under the Chairmanship of Sir Eric Geddes.

78. At the commencement of the Act, when the estimated cost of medical benefit was 6*s.* per head, each Insurance Committee was to enter into agreement with each Approved Society as to the sum to be paid by the Society to the Committee in respect of the cost of medical benefit for its members resident in the area (Section 15 (6) of the Act, 1911). This arrangement being impracticable, the organisation of medical benefit was undertaken by the Central Department.

79. While we agree that the modifications in the method of administration were necessary we suggest that the removal of the duties from the Local to the Central Authority has obscured the intentions of Parliament expressed in Section 15 (7) of the Act of 1911, now Section 85 of the Act of 1924. That Section, which has never been repealed, provides that the Treasury and the Local Authorities may bear some part of the cost of medical benefit beyond the statutory grant.

80. There is moreover a further reason why the provisions of the Act in this respect should be considered. We have already indicated our complete agreement with our colleagues in their recommendations to transfer the administration of medical benefit to Local Authorities. We feel, however, that to bestow powers and duties of such importance and magnitude upon the Local Authorities without any direct financial responsibility, is a departure from the principles of local government hitherto considered essential in this country. We take the view also that the Central Authority exercises its powers of enforcing economy on and of encouraging desirable developments by Local Authorities by reason of the financial arrangements between the two Authorities and we should be more confident of securing efficient development and of enlisting local interest if the usual financial principles operated in respect of medical benefit.

81. We therefore disagree with our colleagues that the first charge on the margin should be the balance of the cost of the present medical benefit and we recommend that the cost of the present medical benefit in excess of the sum of 9*s.* 6*d.* per insured person per annum provided in the Act of 1920 should be borne by the Treasury and the Local Authorities as provided by Section 85 of the Act of 1924. The aggregate cost of this balance is estimated at £2¼ millions.

82. Again, we agree with the recommendations to extend the content of medical benefit by the inclusion of specialist and consultant services, but we cannot agree to the cost being met solely from insurance funds. The need for extension along these lines was realised in 1914, and Parliament voted moneys for the purpose. We submit that these services should also be met under the provisions of Section 85 of the Act of 1924. The estimated cost of the proposed extension is £1½ million a year.

83. We have recommended that medical benefit should include attendance at confinement. We shall refer to the maternity service later and it will suffice at this point to say that we see no season why the cost of this service should not be met from insurance funds.

84. We agree with our colleagues as to the need for dental services and as to the ultimate beneficial effect upon benefit expenditure, but we view with alarm the decision of our colleagues not to include dental benefit as a part of the medical benefit, especially when it is predicted that the aggregate surplus at the second valuation will amount to 40 to 45 million pounds, and that 3,485 Societies and branches in England with a membership of 10,700,000 insured persons " provided some form of dental treatment and this number will certainly be increased when all the schemes under the second valuation become effective."

85. In our opinion there are several grave objections against allowing the present method to continue. We have already submitted that it could not have been foreseen by Parliament that there would be a surplus over the whole insured population sufficient to provide benefits " in the nature of medical benefit " for nearly the whole insured population, otherwise such benefits would have been provided as normal benefits and not as additional benefits. In any case we submit that Parliament should consider the position in the light of experience gained since 1911.

86. A further, and we feel, a fundamental objection to leaving the matter where it is, to be found in para. 81 of the Majority Report. " There is neither uniformity in the selection of benefits nor in the content of the same benefit as given by different Societies, with the result that there is widespread confusion in the minds of the members as to what precisely their rights are," and again, a witness from the Department considers " that the administration of additional benefits in the nature of treatment by Approved Societies can never be very satisfactory." (*Brock*, Q. 23,996.)

87. Another objection is that in some of the smaller Approved Societies " the sum available each year (for additional treatment benefits) . . . would not exceed a few pounds, the whole of which might be exhausted in the first two or three claims for benefit which had to be dealt with." (para. 213.)

88. We cannot pass from this subject without referring to the increased difficulties with which the transfer of the administration of these benefits from Approved Societies will be faced if the administration has been allowed to develop through these bodies to the extent foreshadowed by the valuation figures.

89. The dental benefit which we recommend should form part of medical benefit might at the outset be of such "partial service" as may be organised within the estimate of £2¼ millions a year and we recommend that existing surpluses should be brought into the scheme for the provision of such service.

90. We now come to our recommendation that medical benefit as extended should be available for the dependants of insured persons. It is estimated that the cost of providing for dependants a service equivalent to the present medical benefit would be £9,500,000 a year. We submit, however, that the net cost would be a very much smaller amount. From the statement of evidence submitted by the Ministry of Health as to the scope and inter-relations of the various health services in England and Wales supported by public funds (Appendix CIV) it was shown that the expenditure on medical services other than those associated with mental infirmity amounted to £16,700,000 and the expenditure on medical benefit amounts to about £9¼ millions a year. We have thus an expenditure of £26 millions a year, if to which is added the eight millions spent on mental infirmity, brings us to the sum of £34,000,000 a year for public medical services of one kind or another, of which only a small proportion is borne by the Exchequer. Having regard to the expenditure by the hospitals and payments to medical practitioners in private practice, we see no reason to doubt the statement made by the National Association of Trade Union Approved Societies (Q. 22,046) that apart from the indirect cost to the nation resulting from the limited character of the medical benefit to insured persons and the absence of such services to their dependants, the nation is spending £40,000,000, possibly even £60,000,000 a year on medical services.

91. The case for the co-ordination of all forms of Public Medical Services is to be found in the Majority Report signed by our colleagues. We therefore need not do more at this point than emphasise the conclusion that such co-ordination "should tend to diminish disease and sickness" (*Maclachlan*, Q. 24,226), that "an effective scheme for the treatment of tuberculosis cannot be confined to one section of the community" (*Maclachlan*, Q. 24,092), that the present scheme "has almost certainly reduced national sickness" (*British Medical Association*, Q. 14,613) and that "medically the Insurance Acts have educated the population." (*Brock*, Q. 23,852). We believe it to be unquestionable that a general improvement in the standard of national health has been

effected and that further improvement would follow the extension of medical benefit to the whole nation. "Illness is now coming under skilled observation and treatment at an earlier stage than was formerly the case," is the considered view of the British Medical Association, a development which, however desirable among the insured population, must be even more desirable for young children and mothers. "The public health is the primary asset of the nation's welfare, whether measured by capacity, employability and production or by length of days or by personal well-being." (Annual Report of the Chief Medical Officer, Ministry of Health, 1924, Para. 586) and "Wise progress is not to be looked for in the curtailment of public medical services . . . . but for their prudent establishment and where necessary their extension on sound lines . . . . Public assistance, insurance and education are the three great principles which seem to lie at the foundation of a public health service." (Para. 587).

92. So far from agreeing with the argument that the provision of medical benefit to dependants would postpone or impede the establishment of a fully developed public medical service as foreshadowed in the Majority Report, we feel confident that it would, on the contrary, further the realisation of that scheme. We therefore recommend that Medical Benefit should be provided for the dependants of insured persons and that the immediate expenditure should be met by the Exchequer and the local rates in equal proportions.

Rates of Sickness and Disablement Benefits.

93. The inadequacy of the rates of these benefits would, in our judgment, be sufficient reason for recommending an increase, but attention was drawn to the disparity between the rates of benefit under the National Health Insurance Act and the Unemployment Insurance Act by witnesses representing the Department, Friendly Societies and Trade Union Approved Societies. Sir Walter Kinnear referred to the difference as "rather anomalous" and "as difficult to defend," and expressed an opinion (Q. 473) which supports the view of the Hearts of Oak Benefit Society, that "formerly people on the border line of incapacity would tend to go on the sick fund. They will not do so now, because it pays them to receive unemployment benefit" (Q. 3368). Our colleagues repeatedly express their opinion "that it is difficult to justify a less generous provision for the invalid than for the man who is in good health, whose circumstances certainly involve smaller expenditure."

94. The necessity for uniformity in the rates of benefit does not dispose of the whole matter. We think it not unreasonable to suppose that unemployed persons will delay in obtaining medical advice and treatment under the Health Insurance Act, lest they should be disentitled to the higher rates of the Unem-

ployment Act and so a force is created directly opposed to the public interest and to public health. The evidence of the British Medical Association rather indicates that this undesirable effect of the disparity has been noticed by the officials of Employment Exchanges and goes on to state that medical certificates to the effect that a claimant is fit for work are demanded " whenever the clerk in charge of the Exchange thinks they could not work if they were offered it " (Q. 14,788-14,793).

95. The effect upon health of inadequate maintenance allowance during sickness and unemployment is vividly illustrated in the Annual Report of the Chief Medical Officer of the Ministry of Health for the year 1924, paras. 94 and 95. In his Annual Report for 1923, Dr. Dickinson Leigh, the Tuberculosis Officer for Sunderland, in drawing attention to the check in the decline of tuberculosis, points out that, " The unparalleled poverty and distress due to want of employment is the chief explanation. The want of essential foodstuffs, especially of fats, such as butter and milk, and the lack of suitable clothing and footwear, has markedly lowered the resisting power of the population."

96. In the Report of the Tuberculosis Officer for Newcastle-on-Tyne the increased mortality among women and children from tuberculosis was ascribed to undernourishment and general distress through unemployment; and Dr. James Watt, in the Annual Report of the Metropolitan Asylums Board, suggests the same evil effect of an inadequate standard of maintenance. The obvious effect of insufficient provision for the wage-earner against contingencies of life such as sickness and unemployment, would be a fitting subject to consider in relation to Chapter VI of the Majority Report on the Financial Burden of Existing Social Services. We think, however, it will be agreed that to increase the rates of sickness benefit to the same level as the existing rates of unemployment benefit would be as much in the interest of the prevention of future sickness as in the interest of the sick person at the time of incapacity. We therefore recommend that the normal rates of sickness benefit under the Health Insurance Act should be raised to 18*s.* per week for men and 15*s.* per week for women.

Disablement Benefit.

97. We are not satisfied that Societies generally have administered this benefit as a continuation of sickness benefit at a reduced rate. On the contrary, we feel as has been suggested in evidence by Sir Walter Kinnear (Q. 313), that the test of incapacity has been too rigid. The effect of a rigid or drastic administration of this benefit, which in the main applies to cases of chronic incapacitation, is to throw insured persons out of insurance who from recurring incapacity and ignorance of their legal position allow their " free year " to lapse without enforcing their claim.

98. We know of no way under the Approved Society system, with the " incentive " in operation, of overcoming this feature. We do suggest, however, that the department, when undertaking the enquiries into the administration of this benefit, as recommended in the Majority Report, should direct their attention to the possible effect of a drastic administration of disablement benefit upon the position of an insured person, especially of advanced years, in relation to the Widows', Orphans' and Old Age Pensions Act. We refer to this here in order to call attention to the fact that title to Old Age Pensions will depend to some extent upon the attitude of Approved Societies, and grave injustice might easily ensue from the absence of uniformity which characterises the Approved Society system of administration.

99. What has been said as to the adequacy of the rates of sickness benefit applies with equal, if not greater, force, to disablement benefit and we feel that under the system of administration through local authorities the dangers associated with a comparatively high rate of disablement benefit would be considerably diminished and that the observation of our colleagues on this subject in paras. 312 and 313 would be less applicable.

100. We suggest that the term " disablement benefit " does not properly describe the reduced rate of sickness benefit and is in part responsible for the application of drastic methods of administration. We therefore recommend that even if the benefit is continued at a reduced rate the use of the term " disablement benefit " should be discontinued.

101. In our view, however, the normal rates of sickness benefit should be payable to an insured person so long as he is certified to be incapable of work.

Allowances to Dependants.

102. We further recommend that allowances to dependants shall be provided at the same rates as are provided under the Unemployment Insurance Act.

Maternity Benefit.

103. We regret that the Majority Report does not propose to alter in any way the present provisions under the Act in respect of Maternity Benefit. We have already indicated our view that medical benefit should include medical attention at confinements, not only for insured women, but for all women who would under our proposals be entitled to medical benefit amongst whom would, of course, be included the uninsured wives of insured men.

104. The extension of medical benefit to include all women would remove a difficulty in the way of organising a complete maternity service. The insured woman receives medical attention before and after confinement and a cash benefit. " These two considerations would greatly facilitate the institution

for insured women of a scheme of comprehensive provision of all services required from the time that the woman is first known to be pregnant to the time when she has recovered from the effects of confinement and such schemes have . . . . been considered by . . . . the Department, and discussed with representatives of the medical profession. As regards the uninsured wives of insured men, the difficulty of including this class . . . . arises from the fact that in their case there is at present no provision of general practitioner services such as are afforded by medical benefit." (*Maclachlan* Q. 24,159.)

105. The high maternal death rate and the great amount of sickness amongst mothers clearly prove the need of reorganisation and extension of maternity work. Witnesses directed our attention to the Annual Report of the Chief Medical Officer to the Ministry of Health, in which it is shown that 2,847 women died in childbirth in 1924, and that there has been no diminution of the maternal mortality rate for the whole of the period since the Act came into operation.

106. In no fewer than three recent publications of the Ministry of Health, viz., the Annual Report of the Chief Medical Officer for 1924, "Public Education in Health," and "Maternal Mortality," it is made abundantly clear that "much of this maternal mortality and sickness could be prevented by proper supervision of the expectant mother;" that "avoidable maternal deaths are a matter of everyday occurrence," and that "if a woman can rely upon securing the services of a careful, up-to-date practitioner, or upon the attendance of a well-trained midwife, who is able to obtain prompt and competent medical assistance in case of need, nearly all other conditions become of minor importance."

107. The close connexion between the absence of adequate services during pregnancy and at confinement, and the heavy incidence of sickness among married women was referred to by witnesses (*National Association of Trade Union Approved Societies*, Q. 22,057; *Standing Joint Committee of Industrial Women's Organisations*, Q 23,027; *Maclachlan*, Q 24,226) and may be best illustrated by the following quotation from Sir George Newman's preface to "Maternal Mortality:"— "Returns reveal only part of the damage done. An incalculable amount of unreported and often untreated injury and ill-health results from pregnancy and labour," and "3,000 mothers a year die and tens of thousands of young mothers are unnecessarily damaged or invalided every year. (Public Education in Health.) There is also a close connexion between the absence of adequate services for expectant mothers and the infant mortality rate. While the death rate of infants under the age of one year is about one-half that of 25 years ago, the death rate of infants up to 4 weeks old is 33 per 1,000 births in 1924 against 38 per 1,000 births in 1912 (the commencement of the Act).

108. So far as vital statistics can reveal to the nation directions for extensions of national services, there is a conclusive case for a complete revision of maternity and child welfare services, with a view to the provision of more adequate ante-natal and maternity services.—" This . . . . is a matter that has been discussed . . . . with the medical profession in 1919 and since, and I think the general feeling is that if the requisite financial arrangements could be made it would be very desirable to end the present system under which you have the general practitioner responsible for treatment before labour, but having no responsibility during labour; the midwife under an entirely independent authority, giving attendance in labour and calling in a practitioner to attend in labour if necessary, who would be paid by the local authority; then you have the maternity and ante-natal centre giving assistance in the early stages. There is a great deal of overlapping and probably a good deal of waste, and it would be most desirable if it could be arranged to have a scheme that brought the family doctor, the midwife, the specialist if necessary, and all the services that are available at the maternity centre, under a common scheme and a common control, so that they each played their proper part and were brought into proper relation with one another, helping one another instead of acting at a distance as they do now. I do not think there is any doubt as to the desirability of it . . . . If the insured people were willing or if it were thought desirable to apply part of the present cash maternity benefit so as to make such a scheme practicable, the medical advantages would be very great . . . " (*Smith Whitaker*, Q. 23,896.)

The evidence seemed to show that the medical profession " would welcome an amendment of the Insurance Act whereby attendance at confinement would be brought within the scope of the provision made," provided that certain conditions were fulfilled, and " desire that the same provision should be extended to non-insured women of similar economic position." (Appendix CIII, 46.)

109. We recommend that the medical services during pregnancy and at confinements should be co-ordinated with the maternity and child welfare services under the Local Authorities.

Maternity Cash Benefit.

110. We are not satisfied that there is anything like uniformity in the methods adopted by Societies in administering sickness benefit during pregnancy, nor do we feel that the position is materially better in this respect than in the period reviewed by the Sickness Benefit Claims Committee, and later by the Departmental Committee on Approved Society Administration. We further consider that this important phase of public health cannot be dealt with solely through the Approved Society system. It is significant that the Departmental Committee on Sickness

Benefit Claims in its findings (para. 34) recommended " that a new benefit should be created payable to a pregnant woman in respect of the last four weeks of pregnancy whether she is incapacitated or not, and that payment should be made to a pregnant woman who is incapacitated from following her occupation in the month previous to the last month, whether she is incapacitated by pregnancy alone, or by pregnancy accompanied by some other condition."

111. It was suggested by the National Association of Trade Union Approved Societies (Q. 22,084) that " there are great numbers in Class K, indeed in all classes, who cannot appreciate their rights under the Act, otherwise the number of claims would be much greater than they are," and Sir Walter Kinnear expressed surprise at the low percentage of women who claimed sickness benefit in Class K, and was of opinion that they were " not aware in the early stages that they are entitled to sicknesss benefit " (Q. 24,228.)

112. We submit that the evidence on the subject of the varying practice in the payment of sickness claims during pregnancy amongst Approved Societies, submitted by the Standing Joint Committee of Industrial Women's Organisations is of particular value inasmuch as it may be considered to be the evidence of insured persons themselves.

> " They have got more knowledge of it than they used to have, but there is real chaos on the subject. It is not only the insured women but it is the Societies and the doctors who are also doubtful about it. We have, for instance, information from a doctor that he may not give sickness benefit until the last four weeks of pregnancy. That is a statement of a doctor made to the secretary of one of our women's organisations. We have another statement, in fact we have the same statement, made about two Societies, that they do not give it at all, and about another that they do not give it until the last weeks. Further, there is the fact that some women think they have a right to it at a certain time . . . . On the whole, far fewer women apply for it than need it because of all these doubts . . . . Many insured women cannot afford to have a doctor for their confinement . . . . and they do not like to go and ask him for a certificate during pregnancy when they are not engaging him for confinement " (Q. 23,036.)

113. We submit that maternity benefit should be, in the case of the uninsured wife of an insured man, a cash payment of 20*s*. and in the case of an insured woman, maintenance for the mother and child at a rate not less than that of sickness benefit, for a period of twelve weeks, being not more than six weeks before and six weeks after confinement.

114. The conditions attaching to the payment of this benefit could be designed to encourage such ante-natal treatment as may

be considered desirable. The effect of the combined service and cash benefit would be beneficial in terms of health of mother and child, and later in terms of sickness expenditure saved. " It would do away with the temptation to work too long and to return to work too soon, if something which we should consider full and healthy maintenance for the mother and child was payable " (*Hearts of Oak Benefit Society*, Q. 3496.)

Age at Entry into Insurance.

115. We are not in agreement with the observations of our colleagues with reference to the age of entry into insurance, either in regard to the demand for a lower age of entry, or to the weight of the evidence produced in favour of it. The National Association of Trade Union Approved Societies in their evidence drew attention to the gap of two years between the present statutory school-leaving age and the age of entry into insurance and submitted that " employment within the meaning of the Act should commence at any time after a person has left school, having reached the statutory school-leaving age " (App. XCII, 54).

116. This evidence was submitted to, and endorsed by, the General Council of the Trades Union Congress, which is representative of six and a half million workers, the great majority of whom are insured persons. Further evidence was given by Mr. Gold of the Scottish Miners' Federation Approved Society : " It is a period that we have felt ought to be bridged over . . . . As a matter of fact they are left out of it entirely until they attain 16 years of age although we find that in some instances employers stamp cards immediately the lads commence work " (Q. 6949).

117. In Appendix XI, 4, the Lancashire and Cheshire miners say : " We suggest that the present age of 16 on entry into National Health Insurance shall be reduced to 14 years of age ; or whatever may be the school-leaving age either now or in the future." " The principal reason is not to secure cash benefits but to get the advantage of medical treatment " (*Hibbert*, Q. 7063).

118. The evidence leads us to say that there is a widespread and important demand that there should be available for young persons between 14 and 16 years of age medical services and treatment, not less effective than those available during their school life.

119. We are not impressed by the suggestion that to lower the age of entry will militate against raising the statutory school-leaving age, more especially as we consider that the title to non-cash benefits might partly take the place of cash benefits for

young persons under the age of 16 years. We feel, on the contrary, that as the combined Health, Pensions, and Unemployment Insurance contributions represent a material proportion of the cost of cheap labour, there is a danger of a discrimination in favour of the employment of children under 16 years of age in certain industries. It is not easy to obtain direct evidence that insurance contributions are a factor in this connexion, but the following very guarded statement from the London Advisory Council for Juvenile Employment Report, 1924-25, is illuminating : " Those interested in the industrial welfare of juveniles have thought that the operation of Trade Board rates and the Unemployment Insurance Acts has caused certain employers to discharge their juveniles as soon as they reach 16 years in order to replace them by younger and cheaper workers. The information available has been carefully scrutinised in this connexion; only one per cent of the cases taken in July, 1924, and 0·3 per cent. of the cases taken in December, 1924, appear to have been discharged from this reason, but care should be exercised not to place undue weight on these figures as it is possible that of those whose discharge is attributed to ' slackness of trade,' &c., and amounting to 60 per cent. of the register there may be many who should be included in the category under consideration. In this same connexion it is interesting to note that the largest percentage of unemployed girls was to be found both in July and in December in the 16-17 age group."

120. It might be denied that insurability is a factor but it is not unreasonable to suggest that everything else being accounted for, employers will give preference to uninsured persons.

121. We think that the advantages to the nation of an uninterrupted medical service throughout life completely outweigh any hypothetical disadvantages in relation to a public policy which will in due course be decided from motives not related to National Health Insurance.

122. We recommend therefore (1) that the Act be amended to bring into insurance all persons employed after having reached the statutory school-leaving age; (2) that young persons shall be entitled from the date of their entry into insurance to medical benefit, possibly also a modified cash benefit, and to such treatment benefits as may be prescribed, with such administrative safeguards as may be considered necessary.

Sources of Revenue.

123. We have recommended that the cost of the extension of medical benefit as recommended in the Majority Report and the balance of the cost of the existing medical benefit should be met by the Exchequer and the local rates. We have also recommended

that the cash benefits should be raised to those of the Unemployment Act, which implies similar rates of allowances for dependants.

124. The margin in the present contribution was determined by the Departmental Actuarial Committee to be 1·55*d.* men, and ·82*d.* women. As we observe that the Majority estimate that it will be possible to provide the cost of the proposed extension of medical benefit, taken over the whole country, from the present financial resources of the system, we consider it proper to deduct the contribution value of that cost, namely ·44*d.* per week, from the actuarial calculation of the cost of existing benefits. There is therefore a margin available for our recommendations of 1·99*d.* men and 1·26*d.* women.

125. The Committee estimated that (1) to increase the rate of sickness benefit to that of unemployment benefit with one-half the rate for disablement benefit would add to the contribution of men ·9*d.* and women ·75*d.* (2) the cost of providing dependants' allowances at uniform rates with, and on substantially the same conditions as, the Unemployment Act would represent an increase in contributions of 1·6*d.* for men and ·16*d.* for women, and (3) the provision of maternity services for the wives of insured men and for insured women, would involve an increase of ·44*d.* in the case of men but would allow a reduction of ·11*d.* in the case of women.

126. The net cost of providing the benefits mentioned in the preceding paragraph, excluding the statutory State grant of two-ninths, is 2·94*d.* per week in the case of men and ·80*d.* per week in the case of women. This would leave nearly a penny (·95*d.*) a week to be found from other sources to supplement the contributions of men, but in the case of women, there is a margin of ·46*d.* towards the cost of our further proposals respecting sickness benefit after 26 weeks and maintenance allowance at confinement.

127. Our observations on the administration of sickness benefit to women during pregnancy might here be supplemented to suggest that part of the cost of the proposed maternity allowance would be a growing expenditure under any scheme. In so far as the extra moneys needed for our recommendations could not be provided on the present financial basis we submit that the general opinion, expressed so well in the Majority Report, that such services as we here recommend, will result in a higher standard of health and consequent reduction of expenditure on benefits would justify a further examination of the finances of the scheme, and that still further changes would be possible on the adoption of our recommendation to substitute the Local Authority for the Approved Society as the medium for administering all the benefits under the Act.

Summary of Conclusions and Recommendations.

We append a summary of our main conclusions and recommendations :—

(1) That it is neither necessary nor proper to confine the developments of the National Health Insurance Scheme to such as can be paid for within the present financial resources of the Scheme (para. 3).

(2) That the local administration of additional benefits could be more satisfactorily carried out by the local authorities responsible for other health services than by Approved Societies (para. 7).

(3) That the failure hitherto to give effect to the provisions of Section 107 of the Act as to inquiries into excessive sickness has been largely due to the fact that the Approved Society system is not adapted to the purpose (para. 22).

(4) That the test of good administration is not merely a low expenditure on benefits but the securing also that all insured persons receive the benefits to which they are entitled (para. 37).

(5) That the intentions of Parliament as to the control of Approved Societies by their members have not been realised (para. 40).

(6) That the Approved Society system is a hindrance to the development of a complete public health policy (para. 55).

(7) That it is undesirable to retain Approved Societies any longer as the agencies for the distribution of cash benefits to insured persons (para. 3).

(8) That Local Authorities could and should take the place of Approved Societies as the bodies through whom sickness and disablement benefits should be administered (para. 7).

(9) That there is financial loss due to the overlapping of the various health services at present in operation, and that the money available will be increased when these services are unified and controlled under the Local Authority (para. 59).

(10) That in considering the cost of proposed developments of health services there should be taken into account the loss to the nation resulting from neglect to provide sufficiently for the health of all persons who are or will be employable (para. 60).

(11) That an outlay which safeguards industrial well-being and conduces to efficiency should not be regarded as a burden on industry or on the community (para. 61).

(12) That as the provision of a complete medical and treatment service would tend to prevent sickness and to effect a speedier and more complete cure of illness, it would result in economy of expenditure on cash benefits, and that the provision

of such a service should not, therefore, depend for its finance entirely upon current contributions (para. 66).

(13) That medical benefit should be extended to include attendance at confinement, and dental and ophthalmic advice and treatment (para. 70).

(14) That medical benefit should be provided for the dependants of insured persons (para. 72).

(15) That the transfer to Local Authorities of the responsibility for the administration of medical benefit should be accompanied by some direct financial responsibility on the part of those authorities (para. 80).

(16) That the cost of the present medical benefit in excess of the sum of 9*s.* 6*d.* per insured person per annum, for which permanent provision is made, should be borne by the Treasury and Local Authorities as provided by Section 85 of the Act (para. 81).

(17) That the cost of the extension of medical benefit by the inclusion of a specialist and consultant service should also be met under the provisions of Section 85 of the Act (para. 82).

(18) That the dental treatment to be included in medical benefit might at the outset be restricted to such a partial service as could be provided at a cost of £2¼ millions a year, and that existing surpluses should be made available for the provision of the service (para. 89).

(19) That the normal rates of sickness benefit should be raised to 18*s.* a week for men and 15*s.* a week for women (para. 96).

(20) That benefit at the normal rate of sickness benefit should be payable to an insured person so long as he remains incapable of work (para. 101).

(21) That when an insured person is incapable of work allowances in respect of his dependants should be provided at the same rates as those under the Unemployment Insurance Act (para. 102).

(22) That the high maternal death rate and the great amount of sickness amongst mothers clearly prove the need of re-organisation and extension of the provision for maternity (para. 105).

(23) That the medical services during pregnancy and at confinement should be co-ordinated with the Maternity and Child Welfare service under the Local Authorities (para. 109).

(24) That in addition to medical services during pregnancy and at confinement there should be in the case of an uninsured wife of an insured man a maternity benefit in the form of a cash payment of 20*s.*, and in the case of an insured woman maintenance for the mother and child at a rate not less than that

of sickness benefit for a period of 12 weeks, being not more than six weeks before and six weeks after confinement (para. 113).

(25) That the Act should be amended so as to bring into insurance all persons employed after having reached the statutory school leaving age (para. 122).

(26) That any persons up to the age of 16 should be entitled from the date of their entry into insurance to medical benefit and, in lieu of cash benefits, to such treatment benefits as may be prescribed (para. 122).

(27) That we concur in the recommendations contained in the Majority Report for the improvement of the present Scheme of National Health Insurance in so far as those recommendations are not inconsistent with those set out above.

We desire to associate ourselves most cordially with our colleagues in acknowledging the great services which have been rendered to us by our Secretary, Mr. E. Hackforth, and our Assistant Secretary, Mr. J. W. Peck.

All which, with our humble duty, we submit for Your Majesty's gracious consideration.

(Signed) James Cook.
John Evans.
F. N. Harrison Bell.
Gertrude M. Tuckwell.

22nd February, 1926.

APPENDIX A.

REPORTS OF THE DEPARTMENTAL ACTUARIAL COMMITTEE.

TERMS OF REFERENCE.

I appoint—

Sir ALFRED WATSON, K.C.B., F.I.A., F.F.A., Government Actuary.

A. D. BESANT, Esq., B.A., President of the Institute of Actuaries,

L. E. CLINTON, Esq., F.I.A.,

A. HENRY, Esq., F.I.A., Deputy Government Actuary,

R. G. MAUDLING, Esq., F.I.A.,

to be a Departmental Actuarial Committee to advise the Royal Commission on National Health Insurance actuarially as to whether the present basic contribution under the National Health Insurance Acts is, in fact, required for the existing benefits (including the cost of Societies' and Insurance Committees' administration) or whether such a re-arrangement of the financial basis of the scheme would be justified as would reduce the amount allocated to the present benefits and leave a margin for other purposes; and thereafter to continue in being to furnish such further actuarial advice as may be required by the Royal Commission on any matters arising in the course of their enquiry.

I further appoint Sir Alfred Watson, K.C.B., to be Chairman and M. B. Knowles, Esq., F.I.A., of the Government Actuary's Department, to be Secretary to the Committee.

NEVILLE CHAMBERLAIN.

19th November, 1924.

FIRST REPORT OF THE DEPARTMEMTAL ACTUARIAL COMMITTEE.

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ROYAL COMMISSION ON NATIONAL HEALTH INSURANCE.

REPORT OF THE DEPARTMENTAL ACTUARIAL COMMITTEE.

To the Right Honourable Lord Lawrence of Kingsgate,

Chairman of the Royal Commission on National Health Insurance.

My Lord,

We have the honour to present our Report upon the question submitted to us by the Minister of Health as stated in our Terms of Reference, copy of which is annexed.

1. The present rates of contribution under the system of National Health Insurance are 10d. a week for a man and 9d. a week for a woman, these rates being payable during insurable employment until the age of 70 and providing, *inter alia*, for sickness and disablement benefits in periods of incapacity up to this age. Under the Widows', Orphans' and Old Age Contributory Pensions Act, pensions are provided for insured persons at the age of 65 and, from January, 1928, this age is accordingly substituted for 70 as the limit of insurance for sickness and disablement benefits, and for the payment of contributions, the rates of contribution being reduced, from January, 1926, to 9d. a week for a man and 8½d. a week for a woman.

These contributions are divisible as follows:—

	Men.	*Women.*
	d.	*d.*
Benefit Fund and cost of administration...	$7\frac{4}{9}$	$7\frac{1}{3}$
Reserve Values (interest and redemption)	1	$\frac{9}{10}$
Contingencies Fund*	$\frac{5}{9}$	$\frac{2}{5}$
	9	$8\frac{1}{2}$

2. In the case of an entrant at the age of 16 the contributions to the Benefit Fund provide† on the present actuarial basis for seven-ninths of the liability in respect of benefits (including the cost of administration) the remaining two-ninths being met by Exchequer grants. The question referred to us is, in effect, to determine whether such modifications in the actuarial basis as would reduce these contributions of $7\frac{4}{9}$d. for a man and $7\frac{1}{3}$d. for a woman are justifiable and if so to state the amount of the reduction. Inasmuch as the actuarial basis governs the estimates of the reserves required to support the liabilities of the Approved Societies, as well as the basic contribution, any change by which the contribution was diminished might normally be expected to involve some reduction in these reserves. Practical effect would be given to this reduction by decreasing the reserve values credited to the Approved Societies and this operation might be utilised to shorten the term over which the redemption of the reserve values will extend —estimated at approximately 30 years from the present time—or alternatively to diminish the part of the contribution applied, as shown above, to the service of reserve values (interest and redemption). In the latter event the sum released by the reduction of the basic contribution would be increased. We may say at once that we see no reason to advise a diminution in the length of the redemption period and our recommendation will take this alternative form.

* The joint weekly contributions to the Central and Contingencies Funds are $\frac{5}{9}d.$ for a man and $\frac{2}{5}d.$ for a woman. Of these sums a maximum of $\frac{7}{72}d.$ in the case of a man and $\frac{1}{20}d.$ in the case of a woman may, at the discretion of the Joint Committee, be credited to the Central Fund. At the present time the whole of the above contributions are carried to the Contingencies Fund.

† Owing to changes introduced by the Contributory Pensions Act there is a small margin in the contribution in the case of women, see para. 30 of the Report of the Government Actuary on the Financial Provisions of the Bill (Cmd. 2406).

3. The Contingencies Fund is, in effect, a sub-account of the Benefit Fund to which after each valuation its accumulated balances are transferred. The contributions credited to the Contingencies Fund thus constitute a part of the provision made for benefits and we have regarded the consideration of them as falling within the scope of our terms of reference.

4. The following factors enter into the financial basis of the system:

(*a*) The rate of interest at which the funds are assumed to fructify by investment;

(*b*) the probability of survivorship from age to age;

(*c*) the average amount of sickness and disablement benefit payable in each year of age;

(*d*) the probability that maternity benefit will be payable in each year of age;

(*e*) the probability, at each age, that an unmarried woman will marry and cease to be insurably employed;

(*f*) the probability that an insured married woman will become a widow in passing through each year of age;

(*g*) the claims for sickness and maternity benefit under the special terms and conditions applicable to women who have recently left insurable employment on marriage. (Class K.);

In respect of (*b*), (*c*) and (*d*) the cases of men and women require to be separately considered, and in regard to women the cases of the unmarried (spinsters and widows) and the married must be distinguished so far as concerns (*c*) and (*d*). The factors (*e*), (*f*) and (*g*) arise only in the case of women.

(*h*) the average number of weeks during which an insured person will be unemployed in each year;

(*i*) the cost of medical benefit;

(*k*) the provision to be made for expenses of administration.

The question submitted to us requires us to consider each of these factors. We deal with them, *seriatim*, in the following paragraphs.

5. Before proceeding to this stage we think it necessary to refer to certain considerations which arise out of the peculiar conditions governing the finance of the system of National Health Insurance. The system is operated through a large number of financially independent or semi-independent units, either societies or branches of societies, and these units differ materially from one another in their experience in respect of the greater number of the factors enumerated above. The contributions are not, however, equated to the varying risks undertaken by the separate units; they are uniform in amount for all insured persons of each sex, and the Reserve Values, representing the estimated loss arising from the acceptance of persons of higher ages than 16 at the rate of contribution appropriate to that age, are likewise uniform in amount for all persons of the same age and sex. It follows that widely differing results are found on the valuation of the separate societies and branches, and no rearrangement of the financial basis which retains the present uniformity of contributions can avoid this feature.

The discrepancies between the basic assumptions as to the cost of the risks undertaken and the realised facts of the working of the societies, which are inherent in the existing system, might be held to invest us with a wide discretion as to the provision to be made, on the uniform basis, for the liabilities of the future. It is clear, however, that Parliament intended the scheme to be solvent regarded as a whole whatever might follow from the grouping of risks incidental to the voluntary segregation of insured persons in Approved Societies, and we read our terms of reference as requiring us, in advising any changes, to conform

to this condition. As we shall show, there are in the present basis certain margins over the general average of expenditure to be expected, and we shall advise the release of these margins. It should be understood that we do not include the accrued surpluses of the Approved Societies in the margins to which we refer; we have felt constrained by our instructions from proposing any changes of basis which would involve drafts upon these surpluses. Subject to this reservation the provision which we shall propose to make will be that which, so far as we can estimate, would be required if the whole system were operated through a common fund.

The Rate of Interest.

6. The rate assumed in the present financial basis is 3 per cent. per annum. The actual receipts from interest fall into three categories (i) interest on reserve values, (ii) interest on the credits of the Approved Societies in the Investment Account* maintained by the Department (with which may be included interest on the balances of the societies' current accounts in the National Health Insurance Fund), and (iii) interest on the investments made by the societies, or (where this alternative procedure has been selected by societies) on the investments made by the Department on their behalf. The rate realised is an average dependent on the receipts from these three sources, which, it may be added, are exempt from taxation.

As regards (i), interest is credited on reserve values at the fixed and uniform rate of 3 per cent. per annum and, the reserve values being book credits, is derived from the product of the portion of the contributions retained for the service of reserve values as shown in paragraph 1 above. Receipts under (ii) are also based on a uniform rate; this rate, being prescribed by regulations, may be varied from time to time. It is at present 4½ per cent. per annum, and assuming that after 31st December, 1926, the balances of the interest income of the Investment Account are applied solely to the provision of interest on the credits of Approved Societies, etc., making up the total of this Account, it will evidently be possible to maintain the rate at this figure for a prolonged period. Receipts of category (iii) are derived from interest on trustee securities selected by the individual Approved Societies. The rates vary to some small extent with the types of investment selected by the societies, but the average appears to be about 5 per cent.

7. The average rate of interest to be realised in future, taken over the whole of the funds and credits of the Approved Societies, will depend very largely upon the relation between the amounts of funds (or credits) respectively attributable to those three categories. Reserve values represent at present about 45 per cent. of the societies' assets and, since the interest provided on reserve values is at the rate of 3 per cent. only, the average rate of interest now realised is under 4 per cent. notwithstanding the high rates at which the actual money investments have been made.

In this respect, however, present conditions are about to be greatly altered. The limitation of the sickness and disablement benefits to the age of 65, for which the Contributory Pensions Act provides, will have the effect of reducing the reserve values by about £37,000,000† and, so far as present benefits are concerned, a further reduction in this asset is to be expected as a consequence of the change of basis which we shall find it possible to recommend for the purposes indicated in our terms of reference. Under these new conditions the proportion which

* For convenience the singular number is used: there are in fact three Investment Accounts maintained respectively by the Ministry of Health, the Scottish Board of Health and the Welsh Board of Health, but the procedure is identical throughout. Similarly there are three National Health Insurance Funds.

† Report of the Government Actuary (Cmd. 2406), para. 29.

the reserve values bear to the total assets of the Approved Societies must be materially diminished, and the average rate of interest realised must be correspondingly improved. It is impossible to make a precise estimate of the future rate since the proportion of the total assets which, at the outset of the new arrangements, will be represented by reserve values cannot be ascertained until the details of the new arrangements have been settled. It has, however, been found possible to make certain experiments, involving the probable receipts and expenditure over a considerable future period, and as the result of these we are satisfied that an average rate of 4 per cent. per annum on the whole of the funds and credits of the Approved Societies will be realised in any circumstances likely to arise over the next 25 or 30 years; we consider, accordingly, that this rate may be adopted, instead of the present rate of 3 per cent., in revising the financial basis of the system. It is, however, an integral part of our proposals that the rate of interest credited on the Reserve Values should continue to be 3 per cent. We rely on the high rates secured on the actual investments to produce the average rate of 4 per cent.

8. In coming to this conclusion we have considered it unnecessary to look beyond the period, estimated at about 30 years, over which the redemption of reserve values will extend. As soon as the completion of this operation becomes imminent, the question of the future use of the contributions applied to the service of reserve values will arise, and an opportunity for meeting any difficulty, should such have developed, in connection with the continued maintenance of the basic rate of interest will thus present itself.

9. One further point requires attention in connexion with this subject. If the current rate of interest falls the value of securities yielding high rates of interest will rise above their cost prices and if, in this event, investments are realised with the object of increasing surplus, and the proceeds re-invested, the average rate of interest earned will be reduced. The same result will follow if securities which have appreciated in value are written up to the market prices. If, therefore, so high a rate as 4 per cent. be adopted as the basic rate while a substantial part of the assets, namely the reserve values, is only yielding 3 per cent., it will be essential to place a measure of control upon the results of any operations by which the average rate of 4 per cent. might be endangered. We take it that the power to vary their securities is an integral part of the self-governing functions with which the Approved Societies are endowed; and that to discourage unnecessary or perhaps ill-timed realisation of investments the valuation regulations must continue to include a provision under which investments are taken at their market values for the purpose of the quinquennial valuation. Taking a long view therefore, it would seem that further capital accretions to Approved Societies' funds are to be expected from the future appreciation of security values. In our opinion these accretions should be reserved for the purpose of supplementing the interest income of the Benefit Fund so far as is found necessary to secure the rate of 4 per cent., and only the balances remaining, after this purpose has been served, treated as realised assets. This is a matter for regulations the precise form of which, having made the purpose clear, we do not regard as falling within our province.

The Probabilities of Survivorship.

10. The element of survivorship from age to age exercises an important influence on the liabilities arising under the National Health Insurance system, and in reviewing the financial basis of the system the assumptions made in this respect must be carefully examined with reference to present experience and tendencies. It is perhaps unnecessary for us to enter upon a lengthy explanation of the effect of variations in mortality upon the finance of a system of insurance against incapacity, but it will

be understood that if the tendency of the death rate is to diminish, the proportion of the population surviving to the older ages will be increased with a consequent addition to the liabilities, as originally estimated, for sickness and disablement benefits. The probabilities of survivorship incorporated in the present basis of the system are derived from the mortality experience of the whole population of England and Wales in the years 1908-10. If it were possible it would be desirable to compare this experience with that of the population covered by the system of National Health Insurance. The records of the Approved Societies are not, however, sufficiently complete for this purpose and, to review the basis, recourse must be had to the latest available facts relating to the whole population. It is common knowledge that in recent years the general death rate has fallen substantially, and an approximate measure of the fall since the system of National Health Insurance was established, will be found in Table (A) page 38 of the Report of the Government Actuary on the Financial Provisions of the Contributory Pensions Bill (Cmd. 2406). So far as the future is concerned reasons are given in paragraph 3 of the Appendix to that Report (p. 28) for the assumption that the Life Tables derived from the population of England and Wales at the 1921 Census and the registered deaths in the two years 1920 and 1921 may properly be employed for the purpose of a contributory system which is co-extensive with that of National Health Insurance. For the most part the reasons here given apply with equal cogency to the case of the Health Insurance system and we have accordingly adopted these tables for the purpose of the new basis which we shall recommend.

The Sickness and Disablement Rates.

11. The present basis in regard to sickness and disablement is the Manchester Unity Experience 1893-97 loaded by about 13 per cent. in the case of men and 35 per cent. in the case of women, exclusive of a special provision for married women. So far as men are concerned this basis was adopted at the outset, and has not been subsequently changed. The reasons for its adoption are set out in the first report of the Actuarial Advisory Committee set up in 1912 (published as an Appendix (p. 552) to the Report for 1912-13 on the Administration of the National Insurance Act, Part 1 (Cd. 6907)). The loading is not the result of any exact appraisement of such extra risk as might be expected to be involved in a compulsory and wide-spread system of insurance as compared with that arising under a voluntary system, but is the provision for any feature of the kind that the margin in the original contribution of 7d. a week rendered possible. This margin was fortuitous in its extent since it arose out of the fact that, for administrative reasons, the contribution had necessarily to be an integral number of pence per week. In regard to women the Manchester Unity Experience (which was that of men only) was also adopted originally and with the same margin—about 13 per cent. —in the case of sickness benefit. For disablement benefit the original contribution of 6d. a week enabled the margin to be increased to 19 per cent. Material changes have, however, been subsequently made in the financial basis of women's insurance, chiefly as the result of the Interim Report of the Departmental Committee on Approved Society Finance and Administration (Cd. 8251). The effect, as indicated in paragraph 11 of the Report of the Government Actuary on the First Valuation of Approved Societies (Cmd. 1662), was to increase the addition to the Manchester Unity rates in the case of women by proportions approximating, over all ages, to 35 per cent. A considerable further provision was made for married women, and this is now financed by the grant of special reserve values for women who remain in insurance after marriage.

12. We have been supplied, for the purposes of our enquiry, with two sets of material relating to the recent experience of Approved Societies in respect of sickness and disablement claims. The first of these is a

summary showing, approximately, the percentage which the claims of the whole insured population (in Approved Societies) in Great Britain have borne to the "Expectation," *i.e.*, to the provision made by the existing basis, in each of the six years 1919-24; separate results being given for men and for women. The second is a full statement of the experience in each of the years 1921-22-23 of a group of societies, so chosen as to constitute as nearly as may be in respect of each sex, a microcosm of the whole insured population. These societies included about 500,000 men and 400,000 women, and in the aggregate therefore their records yield observations covering about 1¼ million years of life in the case of men and 1¼ million years in the case of women. The experiences are separately tabulated for the sexes and are given in adequate detail with reference to age. The material was collected and tabulated by the Ministry of Health, and the actuarial analysis, of which summaries are given in the tables appended to this Report, was made by the Government Actuary's Department. We shall refer hereafter to this experience as the "Selected Societies Experience."

13. The summary of the experience of the insured population of Great Britain is contained in the following table. The figures are not exact since (i) it has been impracticable for the purpose of obtaining the "Expected" cost, to take out a complete age distribution of the insured population for each year included in the table and (ii) there are no means of ascertaining the extent to which, on the average of the whole insured population, the benefits have been reduced in each year in respect of arrears. It is believed however that the percentages shown are closely approximate to the actual facts; they are certainly near enough to them to supply an accurate index of the general course of the experience over the years covered by the table.

Percentages of actual to "expected" cost of Sickness and Disablement Benefits in Great Britain.

Year.	Men.		Women.	
	Sickness.	Disablement.	Sickness.	Disablement.
1919	75	42	71	81
1920	65	47	72	94
1921	67	56	80	116
1922	74	66	86	130
1923	66	74	85	146
1924	74	80	96	161

14. *Men.*—Looking first at the men's experience it will be seen that the claims for sickness benefit have varied curiously between two levels, the higher of which has prevailed in the years 1919, 1922 and 1924 and the lower in the years 1920, 1921 and 1923. The higher level is probably explainable by the claims incidental to epidemic sickness, and the character of the fluctuations is such as to create doubt as to whether under existing conditions—including the liability to frequent and sometimes severe visitations of influenza—an experience of even six years' claims is sufficient to give a reliable average. In any case it enforces the need for retaining a reasonable margin if such average be adopted for the purpose of a new basis.

15. The experience of disablement benefit has followed quite a different course, the claims have constantly risen and in 1924 (assuming that in the meantime the expectation had not greatly changed) were nearly double those of the year 1919. The relative magnitude of these figures compared

with the standard is however of some significance. It appears to indicate that in the earlier years of the period covered by the statement some cause was operating to produce an abnormally low volume of claims for disablement benefit and that the trend throughout the period has been towards the development of what may be regarded as normal conditions. We are inclined to think that this is the case. It appears to us that the very low disablement claims of the year 1919 were intimately connected with the low sickness rates of the later years of the war period, and were attributable to the same economic and other conditions which produced those low rates. If this be so, the steady growth of disablement claims for about a decade from the year 1914 (when this benefit first began to be paid) which those concerned were actuarially advised to expect, was sharply interrupted by forces set up by the war, and has gradually reasserted itself as those forces have abated. In the most recent years of the period covered by the statement the growth of disablement claims may, indeed, have been accelerated by economic forces of a directly opposite kind. Widespread unemployment, so far as it influences the sickness experience of Approved Societies, would be expected to have its most pronounced effects on the weakly and debilitated class who supply presumably the major part of the claims for disablement benefit. We are however compelled to say that the recent growth in the cost of disablement benefit has confronted us with serious difficulty in settling the provision to be made for the future. We have suggested a theory to explain it, but this is no more than a theory, and it affords no great assistance in determining the probable weight of the charge when permanent conditions have been reached.

16. Turning now to the Selected Societies Experience, the rates of sickness and disablement obtained will be found respectively in Table A (M.) and Table B (M.) appended to this Report. In these tables are shown for each quinary group of ages, the basic rate of sickness (in weeks of claim per annum) at the central age of the group, the years of life "exposed to risk" in the group in each of the years 1921, 1922 and 1923, the corresponding "expected weeks" of claim, the related actual weeks of claim, and the proportion (per cent.) which the actual weeks bear to those expected. The average proportion for the whole body of persons insured in these Societies is shown opposite the totals for each year. It will be seen that so far as sickness benefit is concerned, there is a tendency for the claims to be above the general average at the younger ages and to be below it at the middle ages. This feature is not, however, of much importance financially and the average percentages for all ages in each of the three calendar years may be taken as representative. These percentages, viz., 66 in 1921, 77 in 1922, and 71 in 1923, are not greatly different from those shown above as representing the experience of the whole of the insured male population. Such differences as exist may be partly due to differences in the distribution of the respective populations with reference to age, and partly to the fact that the statistical treatment of the Selected Societies Experience is practically exact, while that of the whole population is approximate, as explained in para. 13.

17. In regard to disablement benefit the Selected Societies Experience while exhibiting, in the aggregate, the same close relation to the experience of the whole insured male population as exists in the case of sickness benefit, presents quite different features when the experience is examined at the individual age-groups. The claims at the younger ages far exceed the "expectation," but the ratio of actual to expected diminishes steadily until an approximately constant minimum is reached at 50 and all higher ages. Taking the year 1922, for example, the claims for disablement benefit at ages under 30 were about 150 per cent. of the expectation; the proportion steadily diminished, falling to 104 per cent. at ages 35 to 40, and to 77 per cent. in the next age-group; it continued to fall, and was no more than 50 per cent. at ages 50 to 55; thereafter it averaged about 54 per cent. This feature is not easily explained. We

do not think—it is not necessary to elaborate the reasons for our opinion—that it is due to war disabilities. It is probably due, at least in part, to the absence of the customary measures of controlling admission to membership, including medical examination, which were practised in the system of voluntary insurance, the experience of which supplied the financial basis of National Health Insurance. It is, however, by no means certain that this is the whole explanation; in this connection we would draw attention to the study of the Selected Societies Experience contained in the Memorandum appended, which has been prepared by the Government Actuary's Department. It appears to us that questions of considerable administrative importance as to the control of the claims upon Approved Societies are raised by this Memorandum, and pending an examination of these questions by the responsible department we feel precluded from incorporating in the permanent basis of the system a feature which may prove to be capable of reduction by administrative action. Our reluctance to do so is increased by the difficulty which presents itself in the rising cost of disablement benefit to which we have drawn attention in para. 15. Fortunately an alternative course presents itself. The essential thing is to provide at each age for a total outgo in sickness and disablement benefit of an amount which, while it may be approached in actual experience, is not likely to be exceeded in any material degree. On the facts brought out we think that a reasonable provision for sickness benefit would be 80 per cent. of the present provision, and that as regards disablement benefit an ultimate level 33⅓ per cent. above the average of the Selected Societies in the three years 1921-23 might be assumed. On these bases the aggregate outgo at each age would be closely approximate to that shown by the *unloaded* Manchester Unity Experience (1893-97) at all ages under 45, and somewhat below it at ages between 45 and 65. Having regard to these features and to the advantages inherent in utilising an authoritative standard table, we propose to adopt this basis, namely, the Manchester Unity (1893-97) without loading. If, as the result of the administrative enquiries which we advise, the cost of sickness and disablement benefits can be reduced below this standard, some moderate provision for new services in excess of that which we shall now find ourselves able to recommend may be possible at a future day. If, on the other hand, the cost of benefits cannot be influenced by the particular administrative steps to which we refer, the total expenditure should still be within the provision which we propose to make for it, and such further adjustment of the basis as may be desirable hereafter will have no further effect than the transference to the heading of disablement benefit of some part of the provision which we are assigning to sickness benefit. From this point of view it is important to realise that, while an experience of disablement benefit under which the claims are 150 per cent. of the standard must in all circumstances call for attention, it will not in fact occasion loss upon the estimates at a young age if against it can be set a saving of 5 to 10 per cent. on the provision made for sickness benefit. Thus at age 27 the rate of sickness, according to the present standard, is ·78 of a week, while the rate of disablement is ·19 of a week; an excess of 50 per cent. on the expected cost of disablement benefit would thus be balanced by a saving of 6 per cent. on the expected cost of sickness benefit, bearing in mind the fact that disablement benefit is only payable at half the sickness rate. This compensatory influence is in full operation at the present time, and the basis which we propose to adopt will require its continuance should it be found impossible to bring the claims for disablement benefit under closer control.

18. *Women.*—On referring to the statement in para. 13 above, it will be seen that, unlike the corresponding experience in the case of men, the

relation of the sickness claims of women to the standard shows an almost continuous increase. So far as disablement benefit is concerned, the experience agrees with that of men in showing the same feature of continuous growth, the claims, relatively to the standard, in the year 1924, having been almost exactly double those of the year 1919. But the number of women who remain in insurance much beyond the age of 30 is, relatively, so small that we are precluded from thinking that much of the increase can be accounted for by the cause which we have suggested in para. 15 to be operating in the case of men. A substantial part of the increase of the women's disablement claims must, we think, be associated with the increase in the corresponding claims for sickness benefit and be attributable to the same cause—whatever that cause may be.

19. The Selected Societies Experience in regard to women is given in Tables A (S. & W.) and B (S. & W.), which relate respectively to the sickness and disablement claims of spinsters and widows, and in Tables A (M.W.) and B (M.W.), which contain the corresponding data in respect of married women. In regard to sickness benefit a conspicuous feature brought out by these tables is the heavy pressure of the claims of married women. Something of the kind was indeed to have been expected, but the relative amount of the sickness benefit claimed by the married as compared with the unmarried is arresting. An even more disquieting fact is that the relative excess among the married women is growing. Taking, for instance, the important group of ages 25 to 30 the married women's rate of sickness was, in 1921, 1·74 times the unmarried women's rate; in 1922 it was 1·98 times and in 1923, 2·42 times the unmarried women's rate. In respect of disablement benefit the claims of both unmarried and married women have been very heavy (relatively to the standard) at the younger ages, but the relation of the claims of the married to those of the unmarried has varied in a most singular manner, having been favourable at ages between 25 and 45 and unfavourable over 45. These phenomena appear to us to require administrative consideration; their causes are far from clear to us and the prospect of their persistence seriously complicates the problem referred to us. We are required, in fact, to find the proper contribution for the sickness and disablement claims of women at a time when (*a*) the sickness claims of unmarried women at the ages of chief importance are about 40 per cent. higher than the corresponding claims of men and the disparity is increasing; (*b*) the sickness claims of married women are double the corresponding claims of unmarried women, and the disparity is also increasing; and (*c*) the disablement claims of both unmarried and married women are double the corresponding claims of men.

20. It is clear that in these circumstances we cannot come to any final decision. The utmost we can do is to recommend for the time being a basis which *primâ facie* appears to make an adequate provision, relying on (*a*) further actuarial enquiry as to its suitability after the lapse of a few years, and (*b*) in the meantime, an effective administrative investigation of the features to which attention has been directed, with the application of such remedial measures as suggest themselves. In the absence of any authoritative standard of women's sickness experience the basis which we propose should be adopted is that provided by the Selected Societies Experience of women's sickness and disablement claims in the year 1923 with an addition of 10 per cent. But for the experience of the year 1924, as indicated in para. 13, we should have been inclined to think that the experience of the year 1923 provided as high a standard of the future claims as ought to be necessary. In the circumstances we are constrained to add a loading to the 1923 rates which we fix at the moderate figure of 10 per cent. in view of the fact that certain small margins arise in the operation of the system of transfer values.

Maternity Benefit.

21. The experience of the Selected Societies in respect of claims for maternity benefit is shown in Tables C (M.), C (S. & W.) and C (M.W.) for men, unmarried women and married women respectively. The experience, as summarised at the foot of the tables relating to men and married women, shows a declining birth rate from year to year. In the case of men, the relation of the claims to the expectation in the several age groups does not vary greatly from a constant figure except at both extremes of age, and we consider that it will be sufficient to employ issue rates equal to 85 per cent. of those incorporated in the present financial basis. In the case of women, the experience has departed more widely from the basis, and here we think it advisable to use the actual rates of the Selected Societies Experience adjusted to secure a smooth progression from age to age and otherwise so as to produce an over-all margin of about 10 per cent. which, we consider, should be added in view of the low birth-rates in recent years.

22. The remarkably low proportion (51 per cent. over all, as compared with 82 per cent. in the case of men) which the maternity benefit claims of insured married women bear to the standard, calls for comment. The same feature was shown by the Government Actuary in his Report on the First Valuations of Approved Societies (Cmd. 1662), para. 52, to have prevailed over the whole field of National Health Insurance in the period up to 1918, and in view of its persistence after the special conditions of the war years had passed away we are led to think that it is permanent. The present basic rates are constructed from the records of births to married women in a representative community in the year 1910. A general fall in the birth rate has subsequently taken place, but the extent of this is not greater than is indicated in the experience relative to the wives of insured men. The larger part of the difference in the case of insured married women affords a clear indication that a much lower birth rate prevails among married women engaged in industrial employment than among those who are not so engaged

Medical Benefit.

23. The charge upon the funds of Approved Societies for medical benefit is fixed by the principal Act at seven-ninths of a sum of 9s. 6d. per insured person per annum, and in estimating the contribution required to provide the present benefits we have taken the liability on this basis. The sum named does not, however, comprise the whole cost of medical benefit, and further provision of a temporary character is made by the National Health Insurance (Cost of Medical Benefit) Act, 1924, which comes to an end on 31st December, 1926. Such further charges as may be placed upon the funds of Approved Societies after this date in respect of medical benefit will accordingly fall to be met out of the sum which, at a later stage of this Report, we shall advise to be available for new expenditure.

Minor Factors.

24. The present basic assumptions as regards the factor (e) named in para. 4 above have been adopted without modification. The present basis in regard to (f) has been altered so far as is necessary to bring it into conformity with the new Life Table employed, as explained in para. 10 above. So far as concerns (g)—the provision to be made for the sickness and maternity benefits of women in Class K—we have examined the actual experience of the Class both among the Selected Societies and in other important organisations whose data were available to us. On the facts before us we conclude that it will be sufficient to provide for the payment of maternity benefit in 70 per cent. of the cases in which married women enter into Class K and for an average duration of sickness claim of five-eighths of a week. It should be added that on this basis the contributions

will permit of the increase of the sickness benefit of Class K to the ordinary rate (12s. a week), subject to the limit on the period of benefit being retained at six weeks.

As regards (*h*)—unemployment—the position at the present time is abnormal, and, after full consideration, we have made the same allowances as are provided in the present financial basis.

In regard to (*k*)—the provision to be made for expenses of administration—we have estimated the liability on the basis of the allowances provided by the present regulations, viz., 4s. 5d. per insured person per annum to the age of 65 for the expenses of Approved Societies and 6d. per insured person per annum throughout life for the expenses of Insurance Committees.

Effect of the Change of Basis.

25. The effect of the several changes in the basis which we have adopted, as detailed in the foregoing paragraphs, is to reduce the weekly contribution for seven-ninths of the benefits, as computed for an entrant at the age of 16, to the following extent.

In the case of men from 7·44d. to 6·55d.
In the case of women from 7·20d. to 6·85d.

The respective differences between these rates, ·89d. a week in the case of men and ·35d. a week in the case of women are available for the purposes which the Royal Commission may recommend. It will be observed that although the rate of sickness benefit is lower in the case of a woman than in that of a man, and although there are other important differences, tending in the same direction, between the insurance conditions of the sexes, the contribution required at the age of 16 on the new basis is greater in the case of a woman than it is in the case of a man. This is the direct consequence of the heavier sickness and disablement claims among women for which, in view of the facts brought out by the investigation, we have felt compelled to make provision.

26. We pointed out in para. 2 that it was to be expected that any change in the rate of contribution appropriate to an entrant at the age of 16 would be accompanied by an alteration in the reserves required to be held by the Approved Societies and that a resultant change was to be anticipated in the part of the contributions (men 1d. a week, women $\frac{9}{10}$d. a week) allotted to the service of reserve values. We now proceed to investigate this question.

We find that the effect of the change of basis is to reduce the reserves required by the Approved Societies by approximately £9,000,000. This amount falls, therefore, to be deducted from the sum of the reserve values credited to the societies at 31st December, 1926, assuming this to be the date at which the new conditions will be applied.

After giving effect to the changes required by the Contributory Pensions Act,* the aggregate amount of the reserve values on the present basis at this date is estimated, we are informed, to be about £61,000,000. The change of basis reduces this sum to £52,000,000. Another point, however, now arises. The regulations governing the Reserve Suspense Fund require the balances from time to time to the credit of this Fund, so far as they consist of reserve values, to be cancelled, and so far as they consist of actual money to be applied to the redemption of reserve values. We understand that no operations under these regulations have yet been carried through and that, assuming the balances of the Reserve Suspense Fund to be accumulated to 31st December, 1926, they are likely to amount, after providing for certain incumbent charges, to about £17,000,000, of which about £10,000,000 will be represented by reserve

* See Cmd. 2406, para. 29.

values and about £7,000,000 by cash.* The application of these sums in the manner required by the regulations will reduce the reserve values from £52,000,000, as above stated, to about £35,000,000, and this is the sum for the service of which (interest and redemption) the new "Sinking Fund" contribution must provide. As we have already indicated, we see no reason to increase the rate of interest credited on Reserve Values or to arrange for a shortening of the redemption period, which is estimated to extend to about 30 years (apart from any shortening attributable to the transfer of *future* balances from the Reserve Suspense Fund), and we find, therefore, that the part of the weekly contribution retained for the service of reserve values may be reduced from 1d. to ·65d. in the case of men and from ·9d. to ·58d. in the case of women. These reduced amounts are related to the reserves required for the present benefits. As we shall show later, certain additions will have to be made to them should any charges be introduced of a kind which requires the creation of further reserve values.

27. We referred in para. 3 to the possibility of revising the contributions payable to the Contingencies Funds of the Approved Societies. These contributions are at the rate of five-ninths of a penny per week in the case of men and two-fifths of a penny in the case of women, and their annual produce is about £1,400,000. The Contingencies Funds were established in 1918, with retrospective effect, under a recommendation of the Departmental Committee on Approved Society Finance and Administration, and their primary purpose was to provide the societies with the means whence valuation deficiencies of moderate amount might be met from their own resources, thus obviating the necessity for appeal to the Central Fund save in cases of serious insolvency. This purpose has not only been fully served; the cases of deficiency have been relatively few and the bulk of the sums becoming available through the Contingencies Funds has been applied to augment the surpluses distributable under schemes for additional benefits. We regard a marginal provision of the kind made by the Contingencies Funds as of great value, especially in the case of small societies and branches, but its extent must be a matter of judgment and the experience gained by the operation of the system since 1918 leads us to think that the present contribution to these funds may safely be reduced without imposing a serious strain—from either the financial or the administrative point of view—upon the Central Fund. In advancing this view we are influenced to a considerable extent by the fact that as regards the small societies and the branch type of organisations the Act provides for pooling the Contingencies Funds either partly or wholly, thus providing these units with a measure of protection against financial strain far exceeding that afforded by their own individual resources. On the other hand we are compelled to recognise that the imposition of the contemplated new charges on existing resources will, unless other provision is made, entail a considerably greater charge on Contingencies Funds to meet deficiencies in the future than that experienced in the past, but we propose to deal with this important point as a separate question. Assuming that the recommendation which we shall make under this head is accepted, we consider that the weekly contribution to the Contingencies Funds may properly be reduced to one farthing, both for men and for women. Incidentally, we thus advise the abrogation of the present difference between the contributions of men and of women to the Contingencies Funds. In a large number of cases men and women are insured

* These figures must not be taken as an index of the amounts of surplus likely to accrue to the Reserve Suspense Fund in future. The income of this Fund is derived chiefly from transfer values and as the result of (i) the limitation of sickness and disablement benefits to the age of 65 instead of 70 and (ii) the substitution of 4 per cent. for 3 per cent. as the basic rate of interest, transfer values will be materially reduced. Further, a considerable part of the present balance of the Fund is due to the abnormal industrial conditions set up by the War which brought a large number of persons temporarily into employment.

in the same society with a common Contingencies Fund, and having regard to the relative risks of excess in the sickness and disablement claims of the sexes we can see no justification for requiring, in the case of women, a smaller contribution for the purpose of these funds than that called for in the case of men. The effect of this recommendation will be to release from each weekly contribution for the new purposes ·31d. for a man and ·15d. for a woman.

28. Two consequential changes in the present system follow on this recommendation. The first of these relates to the Central Fund. The limit on the sum to be transferred to this fund under the existing statute is one-eighth of the contributions credited to the Contingencies Funds. It is important that the maximum charge upon the resources of the Approved Societies for the support of the Central Fund should not be sensibly reduced, and, since we advise a reduction of rather more than one-half in the sums to be transferred to the Contingencies Funds, we recommend that one-fourth instead of one-eighth of these sums be made available as the maximum draft for the Central Fund.

An analogous adjustment is advised in respect of the pooling provisions of the Act with reference to the Contingencies Funds of the unassociated societies with under one thousand members. At present one-half of these funds is liable to be pooled for the purpose of making good the deficiencies of societies in this category, the other half being reserved for the use of the societies individually. Since our recommendation will so largely reduce the Contingencies Funds, we advise that the whole, instead of one-half in the case of the societies in question, be brought under the liability to be pooled.

29. The margin for other purposes (to use the words of our terms of reference) which, in our opinion, may be taken from the present contribution—subject, in the case of women, to the qualifications expressed in para. 20 above—is obtained by bringing together the margins in the several parts of the contribution as stated in paras. 25, 26 and 27. The combined amounts are 1·55d. per week in the case of men and ·82d. per week in the case of women.

These amounts are made up as follows:—

	Men.	Women.
	d.	*d.*
From the Benefit Fund contribution (para. 25) ...	·89	·35
From the contribution retained for the service of Reserve Values (para. 26)	·35	·32
From the Contingencies Fund contribution (para. 27)	·31	·15
Total	1·55	·82

30. These figures constitute the answer to the question submitted to us, but, since the contribution of which in each case they form a part is payable only until the age of 65 and is intermitted in weeks of sickness and disablement and of unemployment, it remains to be considered for what expenditure the margin will provide in the case of insured persons of each sex. This question admits of a variety of answers according to the nature of the purposes involving new expenditure which may be contemplated. It is not within our province to anticipate the questions which may arise in this connection, but, having regard to the number of possibilities involving the provision of a capitation rate continuing during life which present themselves on examination of the evidence taken by the Royal Commission, we have deemed it advisable to examine the margin from this point of view. We find that with the State grant added it would provide an annual amount of 7s. for a man and 3s. 9d. for a woman, to continue during life or otherwise so long as medical benefit is provided. If the new expenditure took this form some addition to the reserve values would be necessary,

for, while the contribution applicable to the new expenditure would cease at the age of 65, the expenditure would continue during life, and provision would have to be made for the accumulation in respect of each person reaching 65 of a capital sum representing a life annuity at that age of seven-ninths of 7s. or 3s. 9d. a year as the case might be.

On this basis, therefore, the apportionment of the weekly contribution into its component parts would be as follows:—

	Men.	Women.
	d.	*d.*
Benefit Fund (including the new expenditure) ...	7·95	7·65
Reserve Values (interest and redemption) ...	·80	·60
Contingencies Fund	·25	·25
	9·00	8·50

The total amount of the reserve values on this basis would be about £41,000,000, being an increase of £6,000,000 on the sum of £35,000,000 named in para. 26.

As explained in para. 23, the above sums of 7s. and 3s. 9d. would respectively be chargeable with any capitation allowance for medical benefit in excess of 9s. 6d. per annum. Only the balances remaining after such expenditure had been provided for would be available for new purposes.

31. Expenditure at the rate above indicated would amount in total to about £4,500,000 a year (inclusive of State grant), and in the course of a quinquennial period, after allowing for the set-off accruing from the reduction of the contributions applied to the service of reserve values a total charge (with interest) of about £15,000,000 would fall to be met from the funds of the Approved Societies. For the greater part this sum would be met out of resources that, under existing conditions, would emerge as surplus at the quinquennial valuations. We are, however, constrained to point out that the imposition of the new burden would result in increased deficiencies where deficiencies now exist or in the creation of deficiency in certain cases where, on the present basis, surplus would have appeared. As the valuation reports have shown, the societies vary widely in their financial position, and only the margins which have emerged on the present basis have protected a number of them, with, in the aggregate, a substantial membership, from falling into a state of deficiency. The further expenditure contemplated by our terms of reference necessarily involves the reduction of these margins, and this is bound to have adverse results upon the solvency of the weaker units. It is impossible to form any definite opinion as to the membership of the societies which the new burdens would place in deficiency, one of the difficulties of the position being that the numbers would grow as the surpluses hitherto carried forward in sub-normal cases became exhausted and the full force of the new charges had to be met without the possibility of assistance from this source. We are led to expect, after making the best estimates of which the case admits, that the effect of the new burdens would be to create eventually a condition of deficiency in societies representing about 10 per cent. of the whole insured population. This is a grave prospect, and although the machinery of the Central Fund is sufficient, we believe, to meet the situation we do not think we are going beyond our duty in inviting the Royal Commission to consider the effect upon the credit of the whole system of the adoption of changes such as might produce deficiency to the extent here indicated on the valuations of the societies—even though the means of subsequent adjustment existed and were ample for the purpose. We have taken note in this connection of the balances that are likely to accumulate in the Reserve Suspense Fund. Again we are precluded from forming dependable estimates by reason of the new conditions set up by the Contributory Pensions Act, the provisions of which may materially check the present rate of lapse from insurance. But, after giving full weight to the considerations which we

have explained in a note to para. 26, we think that in any circumstances that are likely to arise the balances of the Reserve Suspense Fund will be material, and, having regard to the altered conditions as to reserve values, we see no pressing reason why after 31st December, 1926,* these balances should continue to be applied to the redemption of these credits. We would, therefore, submit for the consideration of the Royal Commission that the balances in question should be made available for grants sufficient to avert the creation of deficiency by the imposition of the new charges in the cases to which we have referred. We think it unlikely that the balances would be insufficient to meet this burden, but a liability to become operative in the event of this contingency arising might, we think, be placed upon the Central Fund.

We are disposed to place the amount required eventually to give effect to this recommendation at something under £1,000,000 in a quinquennial period. We put forward this estimate, however, with much reserve, since the future course of the claims for sickness and disablement on the weaker units (a factor which obviously contains potentialities of great variation) must have a material effect upon the capacity of these units to bear the strain of any new charges.

32. Before concluding this report we think it essential to explain the position so far as our recommendations may affect the surpluses of the Approved Societies. The aggregate amount of surplus carried forward from the valuation of 1922-23 will, we are informed, probably exceed £15,000,000, to which falls to be added the accumulated Contingencies Funds existing at the valuation date and amounting to a further aggregate sum of probably £7,000,000. The subsequent interest earnings on these sums, and the considerable profits that will have accrued from interest earnings in excess of the valuation rate and from other sources must, we think, bring up the total surplus at the end of 1926 to a sum considerably in excess of £30,000,000. This amount, moreover, will be augmented by the contributions credited to the Contingencies Funds subsequent to the valuation, the total at 31st December, 1926, being about £5,000,000. These accrued surpluses with their interest accumulations to the date of the third valuation, will not be affected by our recommendations, but since the new expenditure is to be provided out of what have hitherto been margins, and therefore sources of surplus, the creation of further surplus must be substantially checked, so soon as the new expenditure becomes operative. In these circumstances the surpluses declared on the third valuation will serve a very definite purpose; with their interest earnings and with the related State Grant they will everywhere provide a large part, in some cases, indeed, the major part, of the additional benefits to be provided in the future.

33. We have indicated in the last paragraph that the creation of new surplus will be materially checked if and when our recommendations are carried into effect. It will be understood from this observation that to some extent further surplus will accrue and it is perhaps necessary that we should explain why surplus funds will continue to arise after the adoption of measures of reconstruction by which the available margins in the contributions have been absorbed. The reason is that these margins are calculated on the general average of the working of the scheme, whereas, in fact, it operates through Approved Societies with widely differing experiences. Under such a system both surpluses and deficiencies must arise. Moreover, if the future experience, taken as a whole, should in all respects agree with our assumptions, there would still be a net surplus of moderate amount resulting from the operation of the Contingencies Funds and the Central Fund. Theoretically the amount representing this net surplus could be released as a further margin if the system were, in fact,

* It is an essential condition of our calculations that the estimated balance at 31st December, 1926, should be applied to redeem reserve values as provided by the existing regulations.

operated through a common fund. From the practical point of view we doubt, however, whether any such margin would arise if the approved society system, which has its own administrative advantages, were abrogated.

34. In conclusion we desire to record our appreciation of the services rendered to us by our Secretary, Mr. M. B. Knowles, F.I.A., of the Government Actuary's Department. It has been necessary in the course of our work to require the preparation of a large number of memoranda, many of them dealing with technical questions of great intricacy. We have profited alike by Mr. Knowles's knowledge of the subject and by his willingness to undertake every task we have placed upon him.

We are, My Lord,

Your obedient Servants,

ALFRED W. WATSON (*Chairman*).
A. D. BESANT.
LOUIS E. CLINTON.
ALFRED HENRY.
R. G. MAUDLING.

M. B. KNOWLES (*Secretary*).

13th October, 1925.

TABLE A (M).

Selected Societies Sickness Experience, 1921–23.

MEN.

First six months' Sickness.

Ages last birthday at beginning of year of exposure.	Rate of Sickness provided for in present basis of N.H.I.	Year 1921.				Year 1922.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Weeks.								
Under 20	·888	54,732	48,254	27,506	57	54,991	48,483	33,043	68
20 and under 25	·771	57,393	44,728	33,829	76	59,018	45,994	37,311	81
25 „ „ 30	·783	55,399	43,535	32,405	74	53,933	42,384	36,347	86
30 „ „ 35	·844	56,646	47,862	34,747	73	54,696	46,214	38,945	84
35 „ „ 40	·942	55,727	52,585	34,634	66	54,559	51,483	41,257	80
40 „ „ 45	1·088	55,080	59,941	37,507	63	52,913	57,583	42,182	73
45 „ „ 50	1·267	50,362	63,911	38,203	60	51,255	65,044	46,930	72
50 „ „ 55	1·538	41,360	63,616	39,195	62	41,345	63,592	46,460	73
55 „ „ 60	1·933	31,236	60,207	38,040	63	32,145	61,960	44,966	73
60 „ „ 65	2·469	22,141	54,285	36,613	67	22,150	54,306	42,364	78
65 „ „ 70	3·081	12,367	37,348	28,110	75	12,991	39,232	33,833	86
Total	—	492,443	576,272	380,789	66	489,996	576,275	443,638	77

Ages last birthday at beginning of year of exposure.	Rate of Sickness provided for in present basis of N.H.I.	Year 1923.				Years 1921 to 1923.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
		(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
	Weeks.								
Under 20	·888	55,431	48,871	32,950	67	165,154	145,608	93,499	64
20 and under 25	·771	61,794	48,157	37,378	78	178,205	138,879	108,518	78
25 „ „ 30 ...	·783	52,882	41,558	31,345	75	162,214	127,477	100,097	79
30 „ „ 35	·844	53,434	45,148	33,231	74	164,776	139,224	106,923	77
35 „ „ 40	·942	53,514	50,497	37,105	73	163,800	154,565	112,996	73
40 „ „ 45	1·088	52,451	57,080	40,131	70	160,444	174,604	119,820	69
45 „ „ 50	1·267	50,233	63,746	42,660	67	151,850	192,701	127,793	66
50 „ „ 55	1·538	42,886	65,963	44,117	67	125,591	193,171	129,772	67
55 „ „ 60	1·933	32,581	62,800	43,473	69	95,962	184,967	126,479	68
60 „ „ 65	2·469	23,065	56,550	40,489	72	67,356	165,141	119,466	72
65 „ „ 70	3·081	13,425	40,542	31,450	78	38,783	117,122	93,393	80
Total	—	491,696	580,912	414,329	71	1,474,135	1,733,459	1,238,756	71

TABLE A (S. AND W.).

Selected Societies Sickness Experience, 1921–23.

SPINSTERS AND WIDOWS.

First six months' Sickness.

Ages last birthday at beginning of year of exposure.	Rate of Sickness provided for in present basis of N.H.I.	Year 1921.				Year 1922.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Weeks.								
Under 20	1·104	79,377	87,010	54,086	62	78,651	86,215	56,226	65
20 and under 25	·972	79,157	77,766	58,369	75	76,641	75,294	64,649	86
25 „ „ 30	·974	46,985	45,837	34,454	75	44,774	43,680	38,226	88
30 „ „ 35	1·024	29,890	30,597	21,474	70	28,891	29,575	25,774	87
35 „ „ 40	1·110	22,700	25,213	17,623	70	22,478	24,967	21,848	88
40 „ „ 45	1·244	18,603	23,107	16,856	73	18,074	22,450	17,839	79
45 „ „ 50	1·410	14,958	21,076	14,775	70	15,505	21,846	17,623	81
50 „ „ 55	1·662	11,176	18,567	12,153	65	11,345	18,846	15,168	80
55 „ „ 60	2·036	8,284	16,813	10,367	62	8,543	17,339	13,531	78
60 „ „ 65	2·547	5,687	14,372	8,804	61	5,871	14,837	11,151	75
65 „ „ 70	3·132	2,733	8,391	5,289	63	2,947	9,047	6,753	75
Total	—	319,550	368,749	254,250	69	313,720	364,096	288,788	79

Ages last birthday at beginning of year of exposure.	Rate of Sickness provided for in present basis of N.H.I.	Year 1923.				Years 1921 to 1923.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
		(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
	Weeks.								
Under 20	1·104	80,161	87,870	62,409	71	238,189	261,095	172,721	66
20 and under 25	·972	76,690	75,342	65,176	87	232,488	228,402	188,194	82
25 „ „ 30	·974	42,990	41,940	35,836	85	134,749	131,457	108,516	83
30 „ „ 35	1·024	28,523	29,199	24,780	85	87,304	89,371	72,028	81
35 „ „ 40	1·110	22,137	24,587	19,101	78	67,315	74,767	58,572	78
40 „ „ 45	1·244	18,437	22,901	18,316	80	55,114	68,458	53,011	77
45 „ „ 50	1·410	15,556	21,918	17,901	82	46,019	64,840	50,299	78
50 „ „ 55	1·662	11,901	19,770	15,287	77	34,422	57,183	42,608	75
55 „ „ 60	2·036	8,785	17,830	12,704	71	25,612	51,982	36,602	70
60 „ „ 65	2·547	6,138	15,512	11,451	74	17,696	44,721	31,406	70
65 „ „ 70	3·132	3,183	9,772	6,773	69	8,863	27,210	18,815	69
Total	—	314,501	366,641	289,734	79	947,771	1,099,486	832,772	76

TABLE A (M.W.).

Selected Societies Sickness Experience, 1921–23.

MARRIED WOMEN.

First six months' Sickness.

Ages last birthday at beginning of year of exposure.	Rate of Sickness* provided for in present basis of N.H.I.	Year 1921.				Year 1922.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Weeks.								
Under 20	1·104	687	731	2,327	318	619	659	2,456	373
20 and under 25	·972	7,581	7,387	13,500	183	7,019	6,838	16,825	246
25 „ „ 30	·974	14,215	13,886	18,086	130	13,363	13,054	22,647	173
30 „ „ 35	1·024	14,219	14,577	16,128	111	13,347	13,682	20,315	148
35 „ „ 40	1·110	12,838	14,269	16,213	114	12,334	13,709	18,208	133
40 „ „ 45	1·244	10,702	13,289	13,009	98	10,389	12,901	16,727	130
45 „ „ 50	1·410	7 594	10,683	10,171	95	7,907	11,123	12,855	116
50 „ „ 55	1·662	5,015	8,308	7,813	94	5,084	8,422	9,113	108
55 „ „ 60	2·036	3,169	6,417	5,270	82	3,309	6,701	7,086	106
60 „ „ 65	2·547	1,869	4,705	4,196	89	1,884	4,744	4,750	100
65 „ „ 70	3·132	748	2,295	2,315	101	817	2,506	2,668	106
Total	—	78,637	96,547	109,028	113	76,072	94,339	133,650	142

Ages last birthday at beginning of year of exposure.	Rate of Sickness* provided for in present basis of N.H.I.	Year 1923.				Years 1921 to 1923.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
		(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
	Weeks.								
Under 20	1·104	757	807	2,755	341	2,063	2,197	7,538	343
20 and under 25	·972	7,866	7,664	20,000	261	22,466	21,889	50,325	230
25 „ „ 30	·974	14,142	13,815	28,573	207	41,720	40,755	69,306	170
30 „ „ 35	1·024	13,809	14,156	23,714	168	41,375	42,415	60,157	142
35 „ „ 40	1·110	12,420	13,805	20,797	151	37,592	41,783	55,218	132
40 „ „ 45	1·244	10,894	13,528	18,734	138	31,985	39,718	48,470	122
45 „ „ 50	1·410	8,226	11,571	15,054	130	23,727	33,377	38,080	114
50 „ „ 55	1·662	5,444	9,018	10,417	116	15,543	25,748	27,343	106
55 „ „ 60	2·036	3,415	6,915	6,861	99	9,893	20,033	19,217	96
60 „ „ 65	2·547	2,031	5,114	4,801	94	5,784	14,563	13,747	94
65 „ „ 70	3·132	878	2,693	2,404	89	2,443	7,494	7,387	99
Total	—	79,882	99,086	154,110	156	234,591	289,972	396,788	137

* For convenience of comparison the rate here used is that applicable to Spinsters and Widows, *i.e.* it does not include the small allowance for greater sickness in the case of Married Women for which the present financial basis provides.

TABLE B (M).

MEN.

Selected Societies Sickness Experience, 1921–23.

After six months' Sickness.

Ages last birthday at beginning of year of exposure.	Rate of Sickness provided for in present basis of N.H.I.	Year 1921.				Year 1922.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Weeks.								
Under 20	·054	33,871	1,717	2,626	153	34,359	1,741	3,250	187
20 and under 25	·117	61,758	7,042	8,618	122	62,774	7,158	11,502	161
25 ,, ,, 30	·186	55,806	10,356	10,634	103	54,179	10,054	14,586	145
30 ,, ,, 35	·260	56,177	14,702	13,214	90	54,171	14,178	15,746	111
35 ,, ,, 40	·401	54,992	22,219	17,424	78	53,804	21,738	22,711	104
40 ,, ,, 45	·617	54,308	33,591	22,050	66	52,139	32,249	24,871	77
45 ,, ,, 50	·913	49,691	45,863	24,729	54	50,585	46,689	31,937	68
50 ,, ,, 55	1·552	40,841	63,450	28,980	46	40,831	63,432	31,586	50
55 ,, ,, 60	2·662	30,885	82,628	37,825	46	31,795	85,063	45,303	53
60 ,, ,, 65	4·975	21,933	108,729	48,154	44	21,945	108,788	56,524	52
65 ,, ,, 70	9·577	12,284	112,241	55,393	49	12,907	117,934	67,141	57
Total	—	472,546	502,538	269,647	54	469,489	509,024	325,157	64

Ages last birthday at beginning of year of exposure.	Rate of Sickness provided for in present basis of N.H.I.	Year 1923.				Years 1921 to 1923.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
		(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
	Weeks.								
Under 20	·054	34,542	1,750	3,164	181	102,772	5,208	9,040	174
20 and under 25	·117	65,076	7,420	12,775	172	189,608	21,620	32,895	152
25 ,, ,, 30	·186	52,933	9,822	15,716	160	162,918	30,232	40,936	135
30 ,, ,, 35	·260	52,786	13,814	19,319	140	163,134	42,694	48,279	113
35 ,, ,, 40	·401	52,674	21,282	23,270	109	161,470	65,239	63,405	97
40 ,, ,, 45	·617	51,611	31,923	29,004	91	158,058	97,763	75,925	78
45 ,, ,, 50	·913	49,517	45,702	34,523	76	149,793	138,254	91,189	66
50 ,, ,, 55	1·552	42,338	65,774	37,689	57	124,010	192,656	98,255	51
55 ,, ,, 60	2·662	32,209	86,170	50,698	59	94,889	253,861	133,826	53
60 ,, ,, 65	4·975	22,846	113,255	65,154	58	66,724	330,772	169,832	51
65 ,, ,, 70	9·577	13,337	121,862	76,978	63	38,528	352,037	199,512	57
Total	—	469,869	518,774	368,290	71	1,411,904	1,530,336	963,094	63

TABLE B (S. & W.). SPINSTERS AND WIDOWS.

Selected Societies Sickness Experience, 1921–23. After six months' sickness.

Ages last birthday at beginning of year of exposure.	Rate of Sickness provided for in present basis of N.H.I.	Year 1921.				Year 1922.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Weeks.								
Under 20	·071	46,059	3,066	6,791	221	46,285	3,082	6,379	207
20 and under 25	·157	75,862	11,371	25,957	228	73,443	11,009	28,205	256
25 „ „ 30	·244	45,113	10,893	24,705	227	42,988	10,380	28,477	274
30 „ „ 35	·336	28,659	9,570	18,771	196	27,720	9,256	21,712	235
35 „ „ 40	·501	21,738	10,888	14,737	135	21,562	10,800	18,180	168
40 „ „ 45	·746	17,823	13,258	14,658	111	17,333	12.894	16,240	126
45 „ „ 50	1·074	14,343	15,477	13,338	86	14,919	16,097	16,547	103
50 „ „ 55	1·770	10,708	18,940	12,083	64	10,899	19,278	14,595	76
55 „ „ 60	2·963	7,968	23,686	14,179	60	8,241	24,496	17,698	72
60 „ „ 65	5·424	5,504	29,625	16,592	56	5,696	30,657	18,920	62
65 „ „ 70	10·291	2,676	26,179	15,518	59	2,892	28,292	18,893	67
Total	—	276,453	172,953	177,329	103	271,978	176,241	205,846	117

Ages last birthday at beginning of year of exposure.	Rate of Sickness provided for in present basis of N.H.I.	Year 1923.				Years 1921 to 1923.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
		(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
	Weeks.								
Under 20	·071	46,648	3,106	6,719	216	138,992	9,254	19,889	215
20 and under 25	·157	73,387	11,000	29,939	272	222,692	33,380	84,101	252
25 „ „ 30	·244	41,228	9,955	31,055	312	129,329	31,228	84,237	270
30 „ „ 35	·336	27,364	9,137	24,647	270	83,743	27,963	65,130	233
35 „ „ 40	·501	21,231	10,634	20,066	189	64,531	32,322	52,983	164
40 „ „ 45	·746	17,703	13,170	19,453	148	52,859	39,322	50,351	128
45 „ „ 50	1·074	14,977	16,160	18,572	115	44,239	47,734	48,457	102
50 „ „ 55	1·770	11,461	20,272	19,226	95	33,068	58,490	45,904	78
55 „ „ 60	2·963	8,488	25,231	21,140	84	24,697	73,413	53,017	72
60 „ „ 65	5·424	5,966	32,111	22,738	71	17,166	92,393	58,250	63
65 „ „ 70	10·291	3,129	30,611	23,310	76	8,697	85,082	57,721	68
Total	—	271,582	181,387	236,865	131	820,013	530,581	620,040	117

TABLE B (M.W.).

MARRIED WOMEN.

Selected Societies Sickness Experience, 1921–23.

After six months' sickness.

Ages last birthday at beginning of year of exposure.	Rate of Sickness provided for in present basis of N.H.I.	Year 1921.				Year 1922.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Weeks.								
Under 20	·071	588	42	135	321	538	38	68	179
20 and under 25	·157	6,097	1,019	2,301	226	5,675	948	2,314	244
25 „ „ 30	·244	11,226	2,746	4,282	156	10,650	2,605	4,967	191
30 „ „ 35	·336	11,371	3,836	5,934	155	10,755	3,628	5,888	162
35 „ „ 40	·501	10,756	5,413	7,434	137	10,438	5,252	7,073	135
40 „ „ 45	·746	9,220	6,855	7,549	110	9,039	6,722	8,586	128
45 „ „ 50	1·074	6,637	7,135	8,775	123	7,035	7,564	10,117	134
50 „ „ 55	1·770	4,488	7,882	6,945	88	4,603	8,083	8,667	107
55 „ „ 60	2·963	2,931	8,670	6,435	74	3,092	9,147	7,906	86
60 „ „ 65	5·424	1,771	9,424	6,299	67	1,795	9,551	8,514	89
65 „ „ 70	10·291	723	7,071	5,775	82	794	7,765	7,252	93
Total	—	65,808	60,093	61,864	103	64,414	61,303	71,352	116

Ages last birthday at beginning of year of exposure.	Rate of Sickness provided for in present basis of N.H.I.	Year 1923.				Years 1921 to 1923.			
		Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.	Years of life exposed to risk.	Expected weeks.	Actual weeks.	Percentage of Actual to Expected.
		(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
	Weeks.								
Under 20	·071	692	50	162	324	1,818	130	365	281
20 and under 25	·157	6,489	1,083	3,793	350	18,261	3,050	8,408	276
25 „ „ 30	·244	11,346	2,776	6,602	238	33,222	8,127	15,851	195
30 „ „ 35	·336	11,155	3,763	7,397	197	33,281	11,227	19,219	171
35 „ „ 40	·501	10,481	5,274	8,744	166	31,675	15,939	23,251	146
40 „ „ 45	·746	9,516	7,075	11,195	158	27,775	20,652	27,330	132
45 „ „ 50	1·074	7,337	7,888	11,634	147	21,009	22,587	30,526	135
50 „ „ 55	1·770	4,954	8,700	12,044	138	14,045	24,665	27,656	112
55 „ „ 60	2·963	3,193	9,446	8,959	95	9,216	27,263	23,300	85
60 „ „ 65	5·424	1,940	10,322	10,585	103	5,506	29,297	25,398	87
65 „ „ 70	10·291	855	8,361	8,685	104	2,372	23,197	21,712	94
Total	—	67,958	64,738	89,800	139	198,180	186,134	223,016	120

MEN.

Maternity.

TABLE C (M.).

Selected Societies Maternity Experience.

Years 1921, 1922 and 1923 combined.

Ages last Birthday at beginning of Year of Exposure.	Years of Life exposed to Risk.	Expected Claims.	Actual Claims.	Percentage of Actual Claims to Expected.
Under 20	159,183	1,052	1,145	109
20 and under 25	192,560	16,820	15,416	92
25 „ „ 30	165,789	28,477	24,854	87
30 „ „ 35	165,809	30,088	23,590	78
35 „ „ 40	163,901	22,632	17,413	77
40 „ „ 45	160,175	12,756	9,765	77
45 „ „ 50	151,498	5,678	4,035	71
50 „ „ 55	125,282	1,905	1,203	63
55 „ „ 60	95,757	512	398	78
60 „ „ 65	67,236	123	149	121
65 „ „ 70	38,739	15	54	360
Total	1,485,929	120,058	98,022	82

General average percentages of separate years :

1921	...	...	...	89
1922	...	...	...	80
1923	...	...	...	78

SPINSTERS AND WIDOWS.

Maternity.

TABLE C (S. & W.).

Selected Societies Maternity Experience.

Years 1921, 1922 and 1923 combined.

Ages last Birthday at beginning of Year of Exposure	Years of Life exposed to Risk.	*Claims.
Under 20	223,271	777
20 and under 25	230,710	1,348
25 „ „ 30	133,743	649
30 „ „ 35	86,625	326
35 „ „ 40	66,778	129
40 „ „ 45	54,681	47
45 „ „ 50	45,680	2
50 „ „ 55	34,166	—
55 „ „ 60	25,439	—
60 „ „ 65	17,601	—
65 „ „ 70	8,839	—
Total	927,533	3,278

* Excluding posthumous births.

MARRIED WOMEN
Maternity.

TABLE C (M.W.).

Selected Societies Maternity Experience.

Years 1921, 1922 and 1923 combined.

Ages last Birthday at beginning of Year of Exposure.	Years of Life exposed to Risk.	Expected Claims.	*Actual Claims.	Percentage of Actual Claims to Expected.
Under 20	1,985	1,282	1,113	87
20 and under 25 ...	21,508	9,396	5,772	61
25 „ „ 30 ...	40,025	12,125	6,491	54
30 „ „ 35 ...	39,858	9,081	4,102	45
35 „ „ 40 ...	36,488	5,583	2,118	38
40 „ „ 45 ...	31,205	1,934	584	30
45 „ „ 50 ...	23,233	159	43	27
50 „ „ 55 ...	15,278	—	1	—
55 „ „ 60 ...	9,775	—	—	—
60 „ „ 65 ...	5,738	—	—	—
65 „ „ 70 ...	2,436	—	—	—
Total	227,529	39,560	20,224	51

General average percentages of separate years.

1921	53
1922	51
1923	49

* Including posthumous births.

MEMORANDUM.

An Examination of Certain Features of the Sickness and Disablement Claims of the Selected Societies in the Years 1921-23.

1. The records of the sickness and disablement claims of the "Selected Societies" were sufficiently complete in detail to enable the investigation to include enquiries as to the proportion of members claiming benefit of each kind in each year at the various age groups, with the related average duration of claim. Statistics were also obtainable as to the working of the three days' waiting period and as to the extent to which the claims for disablement benefit represented other than permanent incapacity. The information thus secured is believed to be both of interest and of importance to those engaged in the administration of sickness risks as well as to actuaries who are called upon to deal with the financial aspect of these risks, and it is accordingly presented in Tables I, II and III appended to this memorandum. These tables relate, respectively, to the experience of men, unmarried women (spinsters and widows) and married women.

2. It was desired to compare the new experience with earlier (friendly society) experience in regard to some of the points covered by these tables, but this was only possible in the case of men, since women were not insured against sickness to any material extent before the institution of National Health Insurance and no women's sickness experience of any authority has previously been obtained. The features examined in paras. 3 to 9 below relate exclusively therefore to the experience of men and no corresponding investigation can be made in the case of women.

3. On examining Table I it was found that the sickness claims of men were relatively fewer than in the Manchester Unity Experience, but that the average duration of sickness and disablement was longer than in that experience. This feature has been further investigated and use has been made of the analysed table of the Manchester Unity Sickness Rates contained in p. 593 of the Report for 1912-13 on the Administration of National Health Insurance (Cd. 6907) to obtain approximations to the "proportion sick" in the "first six months" and "after six months" periods respectively and to the proportions entering on the "after six months" period which are necessary for a complete comparison of this standard experience with that of the Selected Societies.

4. The following table relates to sickness benefit (1st six months of sickness). The headings are self-explanatory.

Table 1.

Central Age of Group.	Proportion of Members Claiming Benefit in the Year (per thousand).		Average Duration of Attack in the Year (stated in weeks).	
	M.U., 1893-97 (approximate). (1)	Selected Societies, 1921-23. (2)	M.U., 1893-97 (approximate). (3)	Selected Societies (adjusted for 1s 3 days). (4)
18	302	158	3·0	4·0
22½	236	151	3·3	4·4
27½	232	147	3·4	4·6
32½	232	152	3·7	4·7
37½	236	155	4·0	4·8
42½	246	160	4·3	5·0
47½	258	171	4·8	5·3
52½	273	195	5·4	5·7
57½	300	221	6·1	6·3
62½	328	263	7·0	7·1

5. After making due allowance for the fact that Col. (1) includes all claims, however short, while with few exceptions Col. (2) excludes cases that did not extend to at least four days, it is clear from Table 1 that in National Health Insurance there have been relatively many fewer claims than in the Manchester Unity Experience but that the duration has been more prolonged, especially at ages under 45. These results do not give us any clear indication of what to expect in regard to the corresponding factors in the experience of disablement benefit. On the whole, since the differences between Cols. (2) and (1) are more marked than the differences between Cols. (4) and (3), it would perhaps be reasonable to look for a smaller proportion drawing disablement benefit in the case of the Selected Societies than in the case of the Manchester Unity, especially if the theory that the disablement benefit experience has not yet reached maturity is well-founded. The facts obtained are shown in Table 2. It is necessary to explain in regard to this table that there are two factors as to the proportions receiving benefit which should be distinguished (*a*) the proportion completing sickness benefit and entering on disablement benefit during the year and (*b*) the full proportion in receipt of disablement benefit. This latter includes with (*a*) those on the disablement list at the beginning of the year and those who on first claiming during the year were only entitled to disablement benefit under the "linking-up" provision of the Act.*

TABLE 2.

Central age of group.	Proportion of members reaching disablement benefit in the course of the year (per thousand).		Proportion of members drawing disablement benefit in the course of the year (per thousand).	
	M.U. (approx.) (1)	Selected Societies. (2)	M.U. (approx.) (3)	Selected Societies. (4)
18	3	3	4	5
22½	4	4	6	8
27½	5	6	8	12
32½	6	6	10	13
37½	7	7	13	16
42½	9	8	19	19
47½	12	10	27	23
52½	17	13	42	29
57½	26	19	69	47
62½	40	31	119	81

6. It will be seen that up to age 40 the proportion reaching disablement benefit during the year in the Selected Societies was practically identical with the Manchester Unity Experience, although the proportion who had sickness benefit was very much smaller. This seems to throw up in strong relief the effect of "longer duration." The full proportion drawing disablement benefit is actually greater up to 40 than in the standard experience. This may be due to the existence of a greater proportion of "linked-up" cases. If the greater average duration of sickness benefit is attributable in part to frequent claims from a small section of persons of inferior health at entry, a class which, owing to medical examination,

* Where a person has received sickness or disablement benefit and recovers, any subsequent incapacity is treated as a continuation of the previous incapacity unless a period of one year has elapsed. Otherwise the two attacks are "linked-up" and in such case if sickness benefit is payable at the beginning of the second attack the claimant is not subject to the waiting period of three days. This explains the difference between Cols. (2) and (3) in Tables I, II and III appended.

would certainly have been much smaller in the Manchester Unity Experience, it would necessarily have as its consequence more linking-up, and therefore more short attacks paid at the disablement rate. In the nature of the case this feature would be of less importance at ages over 40 than at the younger ages. The experience at ages over 40 appears, in fact, to confirm the corresponding experience in respect of sickness benefit.

7. The average duration of disablement claims within the year is shown, in weeks, by Table 3.

TABLE 3.

Average number of weeks of disablement benefit within the year.

Central Age of Group.	M.U. (approx.). (1)	Selected Societies. (2)
22½	17·3	20·5
27½	20·6	21·6
32½	23·1	21·9
37½	27·3	24·3
42½	28·8	25·4
47½	30·0	26·3
52½	32·8	26·9
57½	34·2	29·7
62½	37·1	31·4

8. The average duration within the year is, of course, substantially less than the total duration of disablement benefit, since cases of prolonged disablement may extend over several years. In consequence the differences in average duration of claim in the two experiences are somewhat masked in the figures shown above.

By making certain assumptions it is possible to calculate approximately the average total duration of disablement claims, and the resulting figures are shown, in weeks, in Table 4 below.

TABLE 4.

Average total duration of disablement claims stated in weeks.

Central Age of Group.	M.U. (approx.) (1)	Selected Societies (approx.). (2)
22½	26	39
27½	33	44
32½	38	46
37½	51	56
42½	61	58
47½	67	62
52½	81	61
57½	91	72
62½	110	82

9. As might be anticipated the figures confirm those of Table 3, and emphasise the striking differences between the Manchester Unity Experience and that of the Selected Societies.

The duration under National Health Insurance conditions is the longer at the younger ages, but at the older ages the Manchester Unity duration is the greater. At ages over 50 the difference is considerable, and, combined with the smaller proportion of cases, as shown in Table 2 (cols. 3 and 4), explains the relatively favourable experience at these ages brought out in Table B (M.) appended to the Report of the Actuarial Committee.

The results given in Tables (3) and (4) seem consistent with the theory advanced above that the claims contain an appreciable element of "linked-up" illnesses, of relatively short duration, in regard to which the claimant has been disqualified during the year from receiving the higher rate of sickness benefit. This feature may help to explain the high figures shown in column (17) of Tables I, II and III.

10. In view of the rising cost of disablement benefit the "full proportion receiving"—Col. (4) of Table 2—and the "average duration"—Col. (2) of Table 3—have been computed for each of the years 1921, 1922 and 1923. To indicate the run of the figures from year to year it is sufficient to give general averages for all ages. These have been obtained for women (spinsters and widows) as well as for men, and the results are given below.

TABLE 5.

	Men.			Women (S. & W.).		
	1921	1922	1923	1921	1922	1923
Proportion receiving disablement benefit.	·018	·022	·023	·021	·024	·027
Average duration (weeks).	25·7	25·9	27·5	28·6	28·5	29·4

These results seem quite consistent with the theory that disablement benefit is growing towards the equilibrium that should be represented by the maturity of the experience. The proportion in receipt of the benefit grows because the new permanent cases in which the disablement benefit stage is reached are not yet balanced by deaths. The average duration shows, as would be expected if this theory is correct, a small upward tendency. The growth in the claims of men appears to show an indication to end, but no such feature is found in the case of women.

11. Reference is made in para. 9 above to the figures shown in Col. 17 of Tables I, II and III. These figures show for each age group the proportion of those receiving disablement benefit in a year who have "gone off the fund" during the year. These proportions are very instructive, and will dispel any idea that disablement claims in all cases arise out of permanent sickness. So far as men are concerned, it appears that on the average of the years 1921-23 about 45 per cent. of all who claimed disablement benefit in a particular year at ages under 40 ceased to draw it during that year. In the case of unmarried women, the corresponding proportion is about 40 per cent. Among married women, on the other hand, the proportion is over 50 per cent. In each class the proportion "going-off" diminishes as ages advance, but even at ages over 60 it is about 20 per cent.

12. There is no corresponding friendly society experience with which this feature can be compared and it is impossible to form an opinion therefore as to whether it is more prominent under compulsory insurance than under a voluntary system. In any case it seems to invite examination; it suggests that more active administration and especially an increased resort to the medical referee system might result in an earlier termination of many claims that are now prolonged for a brief period into disablement benefit, with resultant saving on both sickness and disablement claims.

13. The differences between the experiences of unmarried women and married women are particularly arresting. Comparison of Cols. (12) and (14) of Tables II and III respectively shows that among married women, both the proportion claiming sickness benefit and the duration of attack were considerably greater than in the case of unmarried women. Comparison of Col. (15) of the two Tables shows that the proportion of married women drawing disablement benefit was also greater, but on contrasting Col. (16) it is found that except at the higher ages the average duration of disablement benefit claims was much less among the married than among the unmarried. This is complementary to the excess in the proportion "going-off" among the married, but it seems quite inconsistent with the general features of the two bodies of experience and, taken in conjunction with the figures set out in the next paragraph, seems to suggest that societies are applying to the disablement claims of married women a degree of activity that might well be exerted, and at an earlier stage, on all claims of prolonged duration.

14. In view of the features shown by Col. (17) of each of the Tables I, II, and III, it was thought probable that instructive results would follow from an investigation of the after-history, up to the end of 1924, of a large number of cases in which insured persons had gone off the fund after drawing disablement benefit. It was not worth while in this connexion to investigate cases in which the "declaration off" had been so recent as 1923, while the necessary data were not available in respect of cases arising in 1921. The work was necessarily limited therefore to the 1922 cases, and even so it would have been prohibitively heavy had it extended over the whole field. A selection was therefore made of societies with a widely distributed membership and representing a substantial proportion of the whole of the data. This selection yielded 1062 cases of men, 609 of unmarried women and 214 of married women, who had ceased to receive disablement benefit in 1922. Each case was then traced through 1923 and 1924 and its benefit history in these years ascertained. The results are set out statistically in Tables IV, V and VI appended. It is proposed to give here no more than a summary of sufficient extent to indicate the conclusions obtained.

15. Taking first the 1062 cases of men it was found that in no fewer than 554 cases the insured person was again a claimant in 1923 and/or in 1924. In 400 of these cases he claimed in 1923 and 254 of the 400 claimed in 1924 as well as in 1923. Further, among the 400 who claimed in 1923, 289 had not been off the funds for 12 months since they ceased to claim in 1922 and these returned to disablement benefit. In 111 cases the member had been off the funds for the full 12 months and, on again claiming, drew sickness benefit. These cases constitute 11 per cent. of the whole number of "declarations off" disablement benefit in 1922. In 34 of them the insured person on resuming benefit drew sickness benefit for 26 weeks and then went on to disablement benefit. In 34 other cases among the 111 the average amount of sickness drawn in 1923 was 7 weeks and in the remaining 43 cases the insured person claimed both in 1923 and 1924 for an average total period of 14 weeks.

16. The same features present themselves in the women's experience. Of the 609 unmarried women who "declared off" disablement benefit in 1922, 286 returned to benefit in 1923 and/or in 1924. Of these, 200 again claimed in 1923 and 54 of them were able to claim sickness benefit. Of this latter number no fewer than 24 remained on the funds to draw the full 26 weeks of sickness benefit and then went on to disablement benefit.

Of the 214 married women who went off disablement benefit in 1922, 102 again claimed in one or other of the two following years, 49 of them claiming in both years. Of the 74 among these 102 who returned to benefit in 1923, 23 had been off the funds for 12 months and returned to sickness benefit; 5 of them remained on the funds for over 26 weeks.

17. It is thus evident that in respect of both men and women the cases of frequent claims (which include many prolonged claims) must account for an appreciable amount of the total expenditure on sickness and disablement benefits. From the point of view of public health as well as from that of administration there is undoubtedly much that deserves attention in this feature of the working of the Health Insurance system.

18. Another matter calling for attention, and in this case calling urgently, is the excess of the claims of married women over those of the unmarried. From Tables II and III (Col. 12) it will be seen that the relative proportions of the total membership claiming benefit in a year are as follows:—

Ages.	*Percentage of Insured Women Claiming Sickness Benefit.*	
	Married.	*Unmarried.*
20-25	32	16
25-30	24	14
30-35	21	13
40-45	21	14
50-55	23	16
60-65	28	20

At the younger ages there may be reason to explain some part of this difference, and in addition, possibly, the greater average length of the claim. But what reason which does not evoke serious reflections can explain the great excess at the higher ages. The figures given, moreover, are an average of the three years. The disproportion, either in the number of claims or in the duration of claim, is rapidly growing, for the main investigation shows that the relation of the average amount of the sickness claims of married women to that of the unmarried is becoming more unfavourable with each succeeding year. For example, at the important groups of ages 20-25, 25-30 and 30-35, the married women's rates of sickness are found to represent the following percentages of those of the unmarried class.

Ages.	1921.	1922.	1923.
20–25	242	284	299
25–30	174	198	242
30–35	158	171	198

On these figures it is impossible to resist the belief that the sickness claims of married women require more effective supervision than they are at present receiving.

The disablement benefit experience is singularly different from that of sickness benefit. Although the proportion of married women who draw disablement benefit is greater than the like proportion among unmarried women, the average duration of the disablement benefit claims among the unmarried is the greater at all ages, and it is much the greater at ages under 45. The figures suggest that the societies tend to concentrate attention on the claims of married women when these have reached the disablement stage. It would seem that a much more comprehensive policy of supervision is called for.

Government Actuary's Department, A. W. W.
Treasury Chambers,
Whitehall, S.W.1.
September, 1925.

TABLE I. MEN

Selected Societies Sickness Experience (Years 1921, 1922 and 1923 combined)

Number of Sickness and Disablement Benefit Claimants, Proportion Sick and Average Weeks of Sickness per Claimant.

Ages last birthday at beginning of year of exposure.	Sickness Benefit.				Disablement Benefit.				Sickness and Disablement Benefits.		
	Years of Life Exposed to Risk.	Number of Claimants.	Number of Claimants subject to waiting period of 1st 3 days.	Weeks of Sickness.	Years of Life Exposed to Risk.	Number of Claimants.	Weeks of Sickness.	Number of cases in which Disablement ceased in the Calendar year otherwise than by death.	Number of Claimants to both Sickness and Disablement included in (2) and (6).	Number of Claimants all periods (2)+(6) −(9).	Weeks of Sickness all periods.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Under 20 ...	165,154	26,051	21,867	93,499	102,772	538	9,040	267	367	26,222	102,539
20 and under 25	178,205	26,990	21,419	108,518	189,608	1,602	32,895	739	850	27,742	141,413
25 „ „ 30	162,214	23,857	18,799	100,097	162,918	1,893	40,936	875	933	24,817	141,033
30 „ „ 35	164,776	25,039	19,490	106,923	163,134	2,201	48,279	998	1,048	26,192	155,202
35 „ „ 40	163,800	25,400	19,591	112,996	161,470	2,612	63,405	1,082	1,137	26,875	176,401
40 „ „ 45	160,444	25,712	19,772	119,820	158,058	2,989	75,925	1,117	1,301	27,400	195,745
45 „ „ 50	151,850	26,026	19,668	127,793	149,793	3,466	91,189	1,278	1,482	28,010	218,982
50 „ „ 55	125,591	24,515	18,057	129,772	124,010	3,653	98,255	1,161	1,615	26,553	228,027
55 „ „ 60	95,962	21,198	15,037	126,479	94,889	4,500	133,826	1,170	1,849	23,849	260,305
60 „ „ 65	67,356	17,693	12,076	119,466	66,724	5,416	169,832	1,178	2,081	21,028	289,298
Total ...	1,435,352	242,481	185,776	1,145,363	1,373,376	28,870	763,582	9,865	12,663	258,688	1,908,945

Ages last birthday at beginning of year of exposure.	Sickness Benefit.			Disablement Benefit.			Sickness and Disablement Benefits.	
	Proportion Sick.	Proportion of Claimants subject to waiting period of 1st 3 days.	Average duration per Claimant in Calendar year.	Proportion Sick.	Average duration per Claimant in Calendar year.	Proportion of Claimants whose claims ceased in Calendar year otherwise than by death.	Proportion of Claimants to both Sickness and Disablement in Calendar year.	Average Duration per Claimant in Calendar year.
	(2)÷(1) (12)	(3)÷(2) (13)	(4)÷(2) (14)	(6)÷(5) (15)	(7)÷(6) (16)	(8)÷(6) (17)	(9)÷(5) (18)	(11)÷(10) (19)
Under 20 ...	·158	·839	3·6	·005	16·8	·496	·003	3·9
20 and under 25	·151	·794	4·0	·008	20·5	·461	·004	5·1
25 „ „ 30	·147	·788	4·2	·012	21·6	·462	·006	5·7
30 „ „ 35	·152	·778	4·3	·013	21·9	·453	·006	5·9
35 „ „ 40	·155	·771	4·4	·016	24·3	·414	·007	6·6
40 „ „ 45	·160	·769	4·7	·019	25·4	·374	·008	7·1
45 „ „ 50	·171	·756	4·9	·023	26·3	·369	·010	7·8
50 „ „ 55	·195	·737	5·3	·029	26·9	·318	·013	8·6
55 „ „ 60	·221	·709	6·0	·047	29·7	·260	·019	10·9
60 „ „ 65	·263	·683	6·8	·081	31·4	·218	·031	13·8
All ages ...	·169	·766	4·7	·021	26·4	·342	·009	7·4

TABLE II. SPINSTERS AND WIDOWS.

Selected Societies Sickness Experience (*Years* 1921, 1922 *and* 1923 *combined*).

Number of Sickness and Disablement Benefit Claimants, Proportion Sick and Average Weeks of Sickness per Claimant.

Ages last birthday at beginning of year of exposure.	Sickness Benefit.				Disablement Benefit.				Sickness and Disablement Benefits.		
	Years of Life Exposed to Risk.	Number of Claimants.	Number of Claimants subject to waiting period of 1st 3 days.	Weeks of Sickness.	Years of Life Exposed to Risk.	Number of Claimants.	Weeks of Sickness.	Number of cases in which Disablement ceased in the Calendar year otherwise than by death.	Number of Claimants to both Sickness and Disablement included in (2) and (6).	Number of Claimants all periods (2)+(6)−(9).	Weeks of Sickness all periods.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Under 20 ...	238,189	37,106	30,928	172,721	138,992	1,141	19,889	557	803	37,444	192,610
20 and under 25	232,488	36,261	28,408	188,194	222,692	3,488	84,101	1,621	1,749	38,000	272,295
25 „ „ 30	134,749	18,525	14,437	108,516	129,329	2,936	84,237	1,104	1,213	20,248	192,753
30 „ „ 35	87,304	11,544	9,016	72,028	83,743	2,140	65,130	741	822	12,862	137,158
35 „ „ 40	67,315	8,653	6,575	58,572	64,531	1,822	52,983	671	732	9,743	111,555
40 „ „ 45	55,114	7,500	5,712	53,011	52,859	1,668	50,351	542	678	8,490	103,362
45 „ „ 50	46,019	6,814	5,061	50,299	44,239	1,608	48,457	528	656	7,766	98,756
50 „ „ 55	34,422	5,563	4,083	42,608	33,068	1,476	45,904	442	585	6,454	88,512
55 „ „ 60	25,612	4,434	3,197	36,602	24,697	1,544	53,017	354	567	5,411	89,619
60 „ „ 65	17,696	3,576	2,485	31,406	17,166	1,655	58,250	319	570	4,661	89,656
Total ...	938,908	139,976	109,902	813,957	811,316	19,478	562,319	6,879	8,375	151,079	1,376,276

Ages last birthday at beginning of year of exposure.	Sickness Benefit.			Disablement Benefit.			Sickness and Disablement Benefits.	
	Proportion Sick.	Proportion of Claimants subject to waiting period of 1st 3 days.	Average duration per Claimant in Calendar year.	Proportion Sick.	Average duration per Claimant in Calendar year.	Proportion of Claimants whose claims ceased in Calendar year otherwise than by death.	Proportion of Claimants to both Sickness and Disablement in Calendar year.	Average Duration per Claimant in Calendar year.
	(2)÷(1) (12)	(3)÷(2) (13)	(4)÷(2) (14)	(6)÷(5) (15)	(7)÷(6) (16)	(8)÷(6) (17)	(9)÷(5) (18)	(11)÷(10) (19)
Under 20 ...	·156	·834	4·7	·008	17·4	·488	·006	5·1
20 and under 25	·156	·783	5·2	·016	24·1	·465	·008	7·2
25 „ „ 30	·137	·779	5·9	·023	28·7	·376	·009	9·5
30 „ „ 35	·132	·781	6·2	·026	30·4	·346	·010	10·7
35 „ „ 40	·129	·760	6·8	·028	29·1	·368	·011	11·4
40 „ „ 45	·136	·762	7·1	·032	30·2	·325	·013	12·2
45 „ „ 50	·148	·743	7·4	·036	30·1	·328	·015	12·7
50 „ „ 55	·162	·734	7·7	·045	31·1	·299	·018	13·7
55 „ „ 60	·173	·721	8·3	·063	34·3	·229	·023	16·6
60 „ „ 65	·202	·695	8·8	·096	35·2	·193	·033	19·2
All ages ...	·149	·785	5·8	·024	28·9	·353	·010	9·1

TABLE III. MARRIED WOMEN

Selected Societies Sickness Experience (*Years* 1921, 1922 *and* 1923 *combined*).

Number of Sickness and Disablement Benefit Claimants, Proportion Sick and Average Weeks of Sickness per Claimant.

Ages last birthday at beginning of year of exposure.	Sickness Benefit.				Disablement Benefit.				Sickness and Disablement Benefits.		
	Years of Life Exposed to Risk.	Number of Claimants.	Number of Claimants subject to waiting period of 1st 3 days.	Weeks of Sickness.	Years of Life Exposed to Risk.	Number of Claimants.	Weeks of Sickness.	Number of cases in which Disablement ceased in the Calendar year otherwise than by death.	Number of Claimants to both Sickness and Disablement included in (2) and (6).	Number of Claimants all periods (2)+(6) −(9).	Weeks of Sickness all periods.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Under 20 ...	2,063	1,029	779	7,538	1,818	39	365	29	32	1,036	7,903
20 and under 25	22,466	7,152	5,255	50,325	18,261	575	8,408	371	384	7,343	58,733
25 „ „ 30	41,720	9,978	7,396	69,306	33,222	917	15,851	546	531	10,364	85,157
30 „ „ 35	41,375	8 855	6,517	60,157	33,281	920	19,219	485	500	9,275	79,376
35 „ „ 40	37,592	7,894	5,728	55,218	31,675	1,078	23,251	531	546	8,426	78,469
40 „ „ 45	31,985	6,716	4,898	48,470	27,775	1,114	27 330	473	564	7,266	75,800
45 „ „ 50	23,727	5,085	3,325	38,080	21,009	1,087	30,526	404	475	5,697	68,606
50 „ „ 55	15 543	3.611	2,549	27,343	14,045	948	27,656	318	388	4,171	54,999
55 „ „ 60	9,893	2,428	1,668	19,217	9,216	740	23,300	216	296	2,872	42,517
60 „ „ 65	5,784	1,625	1,072	13,747	5,506	734	25,398	136	230	2,079	39,145
Total ...	232,148	54,373	39,487	389,401	195,808	8,152	201,304	3,509	3,996	58,529	590,705

Ages last birthday at beginning of year of exposure.	Sickness Benefit.			Disablement Benefit.			Sickness and Disablement Benefits.	
	Proportion Sick.	Proportion of Claimants subject to waiting period of 1st 3 days.	Average duration per Claimant in Calendar year.	Proportion Sick.	Average duration per Claimant in Calendar year.	Proportion of Claimants whose claims ceased in Calendar year otherwise than by death.	Proportion of Claimants to both Sickness and Disablement in Calendar year.	Average Duration per Claimant in Calendar year.
	(2)÷(1) (12)	(3)÷(2) (13)	(4)÷(2) (14)	(6)÷(5) (15)	(7)÷(6) (16)	(8)÷(6) (17)	(9)÷(5) (18)	(11)÷(10) (19)
Under 20 ...	·499	·757	7·3	·021	9·4	·744	·018	7·6
20 and under 25	·318	·735	7·0	·031	14·6	·645	·021	8·0
25 „ „ 30	·239	·741	6·9	·028	17·3	·595	·016	8·2
30 „ „ 35	·214	·736	6·8	·028	20·9	·527	·015	8·6
35 „ „ 40	·210	·726	7·0	·034	21·6	·493	·017	9·3
40 „ „ 45	·210	·729	7·2	·040	24·5	·425	·020	10·4
45 „ „ 50	·214	·713	7·5	·052	28·1	·372	·023	12·0
50 „ „ 55	·232	·706	7·6	·067	29·2	·335	·028	13·2
55 „ „ 60	·245	·687	7·9	·080	31·5	·292	·032	14·8
60 „ „ 65	·281	·660	8·5	·133	34·6	·185	·051	18·8
All ages ...	·234	·726	7·2	·042	24·7	·430	·020	10·1

TABLE IV. MEN.

Analysis of after-history (in 1923 *and* 1924*) of members of certain societies who ceased to draw disablement benefit in* 1922 *otherwise than by death.*

—	Number who ceased to draw Disablement Benefit in 1922 (excluding deaths).	Number of those in col. (1) who drew further Benefit in 1923 and/or 1924.	Number of those in col. (2) who				Average duration of Sickness per claimant in			
			(a) drew further Disablement Benefit only (not having had a year's off-period).	(b) had an off-period of at least a year and then		(c) drew further Disablement benefit in 1923, then had an off-period of at least a year and then drew Sickness Benefit.	Col. (3) Disablement.	Col. (4) Sickness.	Col. (5) 26 weeks Sickness, rest Disablement.	Col. (6) Disablement and Sickness.
				(1) drew Sickness Benefit only.	(2) drew Sickness Benefit and further Disablement Benefit.					
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
(i) Ages 16–40	330	170	70	76	13	11	29·0	8·3	37·3	12·4
(ii) „ 41–60	538	285	140	105	28	12	33·6	9·0	39·0	11·7
(iii) „ 61–70	194	99	53	28	15	3	37·8	9·7	52·9	5·3
(iv) all ages	1,062	554	263	209	56	26	33·2	8·8	42·4	11·2
Analysis of (iv) claimants in 1923 only	—	146	112	34	—	—	11·5	7·0	—	—
Analysis of (iv) claimants in 1924 only	—	154	—	132	22	—	—	7·6	37·4	—
Analysis of (iv) claimants in both years	—	254	151	43	34	26	49·4	14·1	45·6	11·2

TABLE V. SPINSTERS AND WIDOWS.

(i) Ages 16–40		360	175	81	65	23	6	28·7	8·3	44·7	13·9
(ii) „ 41–60		201	87	45	30	11	1	43·4	10·3	46·6	5·0
(iii) „ 61–70		48	24	13	8	3	—	46·6	11·0	36·3	—
(iv) all ages		609	286	139	103	37	7	35·1	9·1	44·6	12·6
Analysis of (iv) claimants in	1923 only	—	64	50	14	—	—	12·9	8·0	—	—
	1924 only	—	86	—	73	13	—	—	8·8	35·5	—
	both years	—	136	89	16	24	7	47·6	11·6	49·5	12·6

TABLE VI. MARRIED WOMEN.

(i) Ages 16–40		116	59	28	25	2	4	22·4	7·0	34·0	20·7
(ii) „ 41–60		88	39	14	18	4	3	23·4	13·2	41·0	8·3
(iii) „ 61–70		10	4	2	2	—	—	88·5	22·0	—	—
(iv) all ages		214	102	44	45	6	7	25·7	10·2	38·7	15·5
Analysis of (iv) claimants in	1923 only	—	25	19	6	—	—	11·9	9·2	—	—
	1924 only	—	28	—	27	1	—	—	9·2	35·0	—
	both years	—	49	25	12	5	7	36·2	12·7	39·4	15·5

SECOND REPORT OF THE DEPARTMENTAL ACTUARIAL COMMITTEE.

To the Right Honourable Lord LAWRENCE OF KINGSGATE,
Chairman of the Royal Commission on National Health Insurance.

MY LORD,

WE submit the following Report on the Questions referred to us in the Secretary's letter of the 20th November, 1925:—

I.—SICKNESS BENEFIT.

1. We are asked to advise as to the cost of raising the standard rates of sickness benefit for men and women respectively to the rates of unemployment benefit. These rates are 18*s.* a week for a man and 15*s.* a week for a woman. We assume that in the first two years of insurance the present sickness benefit of 9*s.* and 7*s.* 6*d.* a week respectively, being one-half of the rates above stated, would be retained. We assume, further, that in the event of the sickness benefit being increased the rate of disablement benefit would be increased to 9*s.* in the case of men, thus retaining the present relation between sickness and disablement benefits. In the case of women, where the available margin in the contribution is relatively very small, we assume that disablement benefit would remain at its present amount of 7*s.* 6*d.* a week. On this basis the rate of disablement benefit would be half the rate of sickness benefit for both sexes.

2. In paragraph 30 of our Report of 13th October, we set out the full contributions required on the assumption that existing benefits would be retained and that new charges taking the form of a payment throughout life of 7*s.* a year per insured man and 3*s.* 9*d.* a year per insured woman would be added to the liabilities. We now understand that the Commission has decided to recommend that charges in respect of medical benefit amounting to 3*s.* a year per insured person throughout life shall be placed on the ordinary benefit funds. Apart, therefore, from such further benefits as may be added to the scheme, the necessary contributions to provide for seven-ninths of the liabilities would be as follows:—

	Men.	*Women.*
	d.	*d.*
Benefit Fund	7·15	7·49
Reserve Values	·71	·60
Contingencies Fund ...	·25	·25
	8·11	8·34

The proposed extension of sickness and disablement benefit would add about £14,500,000 to the Reserve Values and would involve the following additions to the above contributions:—

	Men.	*Women.*
	d.	*d.*
Benefit Fund	·60	·58
Reserve Values	·30	·17
	·90	·75

The full contributions required would thus be brought up to 9·01*d.* (men) and 9·09*d.* (women). The present contribution is 9*d.* for a man and 8½*d.* for a woman. The suggested extension of sickness and disablement benefit would therefore be almost exactly covered in the case of men without an increase of the present contribution provided that the contributions to the Contingencies Fund were not increased as a consequence of the increase of one-fifth in the rates of sickness and disablement benefits. So far as women are concerned, the contribution would have to be increased to at least 9*d.* a week, and if it were no higher than this rate a reduction in the contribution of women to the Contingencies Fund from ·25*d.* per week to ·16*d.* would be necessary. In our previous report (paragraph 27) we stated reasons which led us to the conclusion that the contribution to the Contingencies Fund should be the same for persons of both sexes. Apart from the question of equity which is involved we should view with some apprehension any alteration which substantially reduced, in the case of either sex, the low rate at which we have recommended that the future contribution to the Contingencies Fund should be fixed, even if no extension of risk connected with an increase of benefits were contemplated.

II.—Disablement Benefit.

3. As an alternative to 1, the possibility of an increase of disablement benefit only is submitted to us for examination. So far as men are concerned, we pointed out in paragraph 17 of our previous report that the expenditure on this benefit appeared likely to become stabilised at 33⅓ per cent. above the average of the Selected Societies' Experience in the years 1921-23. This conclusion was, however, founded on observations of expenditure at the rate of 7*s.* 6*d.* a week, and we cannot assume that if in cases of protracted sickness this rate were materially raised, with a consequent reduction of the difference between the rates of sickness benefit and disablement benefit, the volume of claims for disablement benefit or their average duration would remain unaffected. In computing the liability involved in an increase of the rate of benefit we feel compelled, therefore, to provide for a greater amount of claims than will arise with the benefit at its present rate. The extent of the further provision to be made to meet this factor is a point of great difficulty. We do not think that until actual experience has been gained of the cost of the benefit under the new conditions it can safely be put at less than 20 per cent. If it be taken at this rate the margin in the contribution would permit of an increase in the benefit of 2*s.* 6*d.* a week. We recommend, therefore, that if it should be decided to apply the available margin to the increase of disablement benefit, the rate of this benefit should not be raised to more than 10*s.* a week in the case of men.

4. In the case of women, the margin in the contribution is only ·16*d.* a week (after providing for the increased cost of medical benefit), and it is sufficient to say that this margin, with the related State grant, would not allow of the increase of the present disablement benefit of 7*s.* 6*d.* a week by more than ninepence.

III.—Benefit to Dependants.

5. We are asked to advise on the cost of providing allowances, similar to those under the Unemployment Insurance scheme, in respect of the wives and children of insured persons in receipt of sickness or disablement benefit. We assume, in regard to the wives of insured men, that the proposal is to pay the dependants' benefit in all cases in which an insured man is married, not excluding those cases in which the wife is herself a wage earner. Such a wife is not ordinarily a dependant for the purpose of Unemployment benefit, but if it were proposed to exclude her from this benefit under the Health Insurance system, while retaining the "flat rate" contribution for the whole body of insured men, a point of some difficulty in the financial operation of the system would arise.

We estimate that of the married men who are insured under the scheme of National Health Insurance about one-seventh have wage-earning wives. The distribution of this class of wives with reference to industry as a whole is, however, very uneven, a large proportion of the whole number being employed themselves, and being the wives of men employed in the textile industry, while among other industries, as for example, coal-mining, the employment in industry of the wife of the insured man is very rare. It follows that if wage-earning wives were excluded from the definition of dependants and financial provision made accordingly, the present deviations from the general average, which result from the system of insurance through approved societies, would be accentuated. At the same time we do not regard the point as one of such importance as to justify us in advising that dependants' benefits should be insured through a central fund, with all the complications of finance and administration that such an arrangement would involve. The alternative is to provide actuarially for the payment of the benefit in all cases in which an insured man is married, in which event a small margin would enure to the financial advantage of the societies concerned should it be decided to exclude the employed wife from the definition of a dependant.

6. With regard to children the qualification in the Unemployment Insurance and Widows' &c., Pensions Acts is that the child is under the age of 14 or the age not exceeding 16 up-to which the child remains under full-time instruction in a day school. In view, however, of the administrative difficulties which would arise in establishing the dependency of children over the age of 14, we are asked to frame our estimates on the basis that benefit would be limited to cases of children not exceeding the age of 14. Further, we are instructed that in all cases children should be regarded as dependent upon the father only, whether he is insured or not and without regard to the question whether the mother is herself insured.

7. The estimates set out below relating to insured men provide therefore for the payment of sickness or disablement benefit in all cases in which the man is married or, being a married man or widower, has children under the age of 14. The special data required are given in Tables B and D of the Report of the Government Actuary on the Contributory Pensions Bill (Cmd. 2406). In other respects the basis of the calculations is in conformity with that adopted for our previous estimates as explained in our Report of 13th October, 1925.

We have ascertained in the first instance the contribution necessary to provide for sickness benefit for dependants at the rates of the Unemployment Insurance scheme, namely, 5*s*. a week for a wife and 2*s*. a week for each child, with one-half of these rates during disablement benefit, with an additional allowance of 5s. a week (corresponding to the wife's benefit in the case of a married man) for a widower with children. The administration of benefits of this type would, we presume, impose some additional labour on the approved societies; we have accordingly assumed that it would be necessary to make some increase in the present administration allowance, and for this purpose have assumed that the rate of 4*s*. 5*d*. would be increased to 4*s*. 8*d*. We estimate that the necessary contribution for seven-ninths of the new charges would be as follows:—

	d.
To the Benefit Fund per week	1·00
To Reserve Values	·60
	1·60

As we have explained earlier in this Report, the contribution required to support the present liabilities of the system, with a further charge of 3*s*. a year in respect of medical benefit is 8·11*d*. a week. If to this

rate of 8·11*d.* there is added seven-ninths of the cost of dependants' benefits for wives and children at the rates above set out the total contribution required is brought up to 9¾*d.* a week, being an increase of ¾*d.* a week over the present joint contribution of employer and worker.

It will be observed that the actual margin in the present contribution after providing for the extra 3*s.* for medical benefit is ·89*d.* per week, being the difference between 9*d.* and 8·11*d.* We find that this margin, with the related State grant, would be sufficient to provide an addition of 2*s.* a week to sickness benefit and of 1*s.* a week to disablement benefit in respect of the wife of an insured man (corresponding sums being available in the case of a widower with children) and the same sums in respect of each child of a married man or widower; the administration allowance being increased as explained above.

8. As regards insured women, we are instructed, as stated above, that in the case of an insured married woman her children are to be regarded as dependent on her husband, whether he is insured or not. We are asked to advise as to the weekly addition to sickness benefit (with one-half the addition to disablement benefit) which the margin in the women's contribution would provide in respect of each child under the age of 14 of an insured widow and in respect of the dependent widowed mother of an unmarried insured woman. We have assumed that the latter category may include widows.

As stated in paragraph 4, the margin in the woman's contribution after providing for a further charge of 3*s.* a year in respect of medical benefit is ·16*d.* per week. We find that this margin is sufficient to provide an addition to sickness benefit of 2*s.* a week and to disablement benefit of 1*s.* a week for the classes of dependants mentioned, with the same increase in the allowance for administration as stated above.

We are, My Lord,

Your obedient Servants,

ALFRED W. WATSON (*Chairman*).
A. D. BESANT.
LOUIS E. CLINTON.
ALFRED HENRY.
R. G. MAUDLING.

M. B. KNOWLES (*Secretary*).

7th December, 1925.

THIRD REPORT OF THE DEPARTMENTAL ACTUARIAL COMMITTEE.

To the Right Honourable Lord Lawrence of Kingsgate,
Chairman of the Royal Commission on National Health Insurance.

My Lord,

1. We have received from the Secretary to the Royal Commission a request to advise on the question of the cost which would be involved in replacing the present maternity benefit by a new service to include all necessary medical attendance during pregnancy, the services of a midwife and (where required) a doctor at confinement, ante-natal and post-natal examinations and a money payment. An estimate of the fees to be paid to doctors and midwives under various headings of the projected service has been prepared by the Ministry of Health, and we have taken these estimates, which we are, of course, not in a position to review, as the basis of our calculations. At the present stage we have deemed it sufficient to take the cash payment as £1.

2. The problem is complicated by considerations as to the liability to be provided for in those cases in which both husband and wife are insured. The new services will only have to be provided in respect of one insurance and the question arises whether in the case where both are insured the provision should be made under the insurance of the husband or under that of the wife. Having regard to the amounts of the available margin in the respective contributions of men and of women, we have assumed that the liability would be placed upon the husband's insurance.

3. A somewhat analogous question arises as to the cost of ordinary medical attendance during pregnancy. In this case a married woman who is herself insured is entitled to this service as part of medical benefit, and we assume it to be inexpedient that this arrangement should be disturbed. So far, therefore, as concerns this particular item in the services proposed to be given, we assume that a charge will only be imposed on the insurances of men to cover the cases in which the wives are not insured.

4. The several items of the service, with their estimated cost which have been supplied to us, are as follows:—

	s.	*d.*
(1) Fee to midwife	30	0
(2) Fees for ante-natal and post-natal examinations ...	10	0
(3) Fee for risk of doctor's personal attendance on confinement	5	0
(4) Fee for medical attendance during pregnancy	10	6

To these should be added:

(5) Cash benefit, which is taken at	20	0

5. The various combinations of these items which arise and the distribution of their cost are as follows:—

(A) *Husband insured: wife uninsured.*

The charge of £3 15*s.* 6*d.*, comprising items (1) to (5), arises and falls on the husband's society in lieu of the present provision of £2—an additional liability of £1 15*s.* 6*d.*

(B) *Husband insured: wife insured.*

Item No. (4) is covered by existing medical benefit provided by the wife's society. The husband's society will, therefore, bear a charge of £3 5*s*. It is assumed that as the wife is independently insured a sum of £1 in cash will be paid to her by her society in addition to the payment of £1 by her husband's society. At present a payment of £2 is made by both the husband's society and the wife's society. The new provision thus represents an increase in the liability on the former of £1 5*s*. and a decrease in the liability on the latter of £1.

(C) *Husband uninsured: wife insured.*

The new medical charges (items (1)-(3)) will amount to £2 5*s*., item (4) being already covered.

As regards the cash benefit, under the existing Act an *employed* married woman's society pays two maternity benefits of £2 each in the exceptional case in which the husband is not an insured person. This provision does not, however, apply in the case of a woman who has ceased to be employed on marriage, and who is entitled to special benefits for a limited period (Class K).

The provision of a double benefit from the one society in the case under consideration has been much criticised, and in view of the fact that under the proposals before us the woman's society would have to pay £2 5*s*. for new medical services in this case, whereas it would have to pay nothing under this head where the husband was also insured, we consider that the double cash payment by the woman's society, where the husband is not insured, should be terminated. The new cash benefit, where the woman only was insured, would thus be limited to a single sum of £1 both for the employed married woman and the "Class K" woman, making a total payment of £3 5*s*. in each case. The society would thus pay 15*s*. less in the case of an employed married woman and £1 5*s*. more in the case of a "Class K" woman than at present.

(D) *Unmarried Women.*

The new services would be items (1), (2), (3) and (5), No. (4) being already covered by medical benefit.

6. The relative numbers of the cases A, B and C have next to be considered. As a preliminary, it is necessary to determine the proportion of married women, either employed or "Class K," whose husbands are not insured. We find that in settling the present financial basis of the system the former Actuarial Advisory Committee assumed that one-tenth of the married women who were employed contributors would have uninsured husbands and, on such facts as we have been able to obtain, we do not consider that any other proportion would be more appropriate. As regards the women of "Class K," we recognise the probability that among this class, consisting of recently married and therefore, for the most part, young women, the proportion whose husbands are not insured would be materially less than that obtaining among the married women who are working for employers. The question of discrimination is not, however, of material importance to the estimates of cost (though the matter assumes another aspect in regard to the arrangements to be made to meet the actual cost of the medical service contemplated), and we propose, therefore, to adopt the same proportion, namely, 10 per cent.

7. Coming now to actual numbers, we have obtained the following estimate, on the basis of the rates of issue adopted in our first Report,

of the expected number of claims for maternity benefit in Great Britain in the year 1926:—

I. Wives of insured men	684,000
II. Insured married women	94,000
III. ,, ,, ,, (Class K) ...	91,000
IV. Insured unmarried women	15,000

Since 90 per cent. of II and III, or 166,500, are also included (as estimated) in I, there are taken to be 517,500 confinements of uninsured wives of insured men, or say 76 per cent. The average liability falling on a man's society in respect of the confinement of a wife of one of its members is therefore:—

	£
76 per cent. of £3 15*s.* 6*d.* (Case A)	2·87
24 per cent. of £3 5*s.* (Case B)	·78
	3·65
Towards which the present maternity benefit provides	2·00
Further provision required	1·65

The average liability falling on a woman's society in respect of the confinement of an insured married woman is:—

	£	
90 per cent. of £1 (Case B) ...	·900	
10 per cent. of £3 5*s.* (Case C)	·325	
	1·225	
Against which there is a present (average) provision of ...	2·200	(2·0 "Class K")
The new provision therefore involves a reduction of ...	·975	(·775 "Class K")

In the case of an unmarried woman the new charge on her society is £3·25 against a present provision of £2: increase, £1·25.

8. The effect of these provisions on the contributions, including the necessary adjustments of the contributions applicable to the service of Reserve Values, and after making allowance for the State grant, is as follows:—

(*a*) The necessary increase of contribution in respect of men is ·44*d.* per week. We have previously reported that after providing an additional 3*s.* per year (throughout life) in respect of medical benefit the contribution required for existing benefits is 8·11*d.* a week, leaving a margin of ·89*d.* The projected new provision in respect of maternity services would therefore absorb almost exactly one-half of this margin. This estimate would, however, be varied if the cash payment of £1 to the mother, on her confinement, were altered.

(*b*) In the case of women, the saving on the present payments in respect of married women would much more than counterbalance the additional expenditure on the cases arising among unmarried women. The net effect would be to reduce the requisite contribution for all benefits from its present figure of 8·34*d.* to 8·23*d.*, thus increasing the margin from ·16*d.* to ·27*d.*

The annual sum (inclusive of State grant) which would emerge if these margins were applied to provide benefits throughout life would be about £1,050,000 in the case of men and £300,000 in the case of women.

9. It will be seen that we have related the charges arising under the new proposals to the expected number of claims for maternity benefit. We understand, however, that charges in respect of certain of the items of medical service would arise in cases of miscarriage, particularly where there is no present liability to provide medical benefit. We have made enquiries as to the probable weight of these charges, and are advised that relatively to the total number of cases they are likely to be few in number and are expected to involve a very small addition to the total cost. We deem it unnecessary, therefore, to make specific provision for this factor, regard being had to the small margins which are likely to arise in respect of other elements in the cost of the scheme.

10. While we have found ourselves able to supply a reasonably close estimate of the cost of the proposed new services on the aggregate resources of the Approved Societies, we have become impressed in the course of our work by the fact that difficult administrative problems are involved in the scheme and that the methods adopted for the solution of these must to some extent affect its financial incidence. We have shown that as between different types of cases, e.g., where the husband of an insured woman is himself insured or is not insured, there are considerable differences in the liabilities respectively falling upon particular societies. There are, however, no records in the system of National Health Insurance with reference to the insurable status of spouses, and it is not easy to see how in these circumstances the total charges can be distributed equitably between the different societies. Whether the distribution should be effected on some approximate basis, or whether an exact distribution should be attempted seems to involve the question whether widespread enquiries as to the insured status of wives and husbands of insured persons could be undertaken with the hope of success and without prohibitive cost. We cannot ourselves pursue this point further, but submit it to the Royal Commission as one which would have to be dealt with if the projected extension of services were undertaken.

11. One other point in connection with this reference remains to be mentioned. It has been assumed that an insured married woman is to be entitled to medical benefit throughout the period of pregnancy. In fact, the woman in "Class K" is entitled to maternity benefit on her first confinement after marriage if it occurs within two years of the date of marriage, while her title to medical benefit runs to a particular 30th June or 31st December, as dictated by the date on which she ceased to be employed, and may therefore cease in some cases before her confinement. We understand it to be intended that the new services would be available for all women at present entitled to maternity benefit while in "Class K"; it would, therefore, seem that the provisions of the Act as to medical benefit in these cases should be examined.

We are, My Lord,

Your obedient Servants,

ALFRED W. WATSON (*Chairman*).
A. D. BESANT.
LOUIS E. CLINTON.
ALFRED HENRY.
R. G. MAUDLING.

M. B. KNOWLES (*Secretary*).

18th December, 1925.

APPENDIX B.

Alphabetical List of Persons and Representative Bodies by whom evidence was submitted to the Commission.

I.—PERSONS.

Witness.	*Statement of Evidence. Pages in Appendix to Minutes of Evidence.*	*Oral Evidence. Pages in Minutes of Evidence.*
Addly, T. J.	584–585	987–990
Arbuckle, W.	579–581	961–969
Asher, A.	553–555	915–921
Aves, O.	500–511	836–847
Badcock, J. H.	259–264	432–447
Bailey, H.	213–217	306–319
Barker, Miss J. C.	565	944–951
Barker, W. B.	518–524	855–861
Barnby, J. H.	598–599	1024–1028
Baskett, B. G. M.	748–749	—
Bateman, F. W.	511–517	847–855
Bickerton-Edwards, W.	486–488	778–783
Bilbey, V. L.	421–424	646–649
Blizard, G. P.	614–622	1047–1066
Bolam, R. A.	443–461	693–735
Bott, E. G.	594–595	1019–1021
Bowden, L.	585–586	991–1000
Bowen, W. F.	295–297	519–527
Brackenbury, H. B.	443–461	693–735
Braithwaite, W. J.	612–613	1043–1047
Bremner, Miss G.	563–564	940–944
Brenchley, A. D.	594–595	1019–1021
Broadbent, B.	275–276	478–482
Brock, L. G.	76–101 170–172 664–674 674–683	44–87 1160–1194 1229
Buchan, J. J.	493–497	807–818
Buchanan, J. C.	497–498	819–826
Bunnett, F.	587–588	1000–1004
Butterfield, F.	295–297	519–527
Cadell, H. F.	560–563	930–940
Cameron, Miss A. H.	440–442	687–693
Canter, G. W.	252–259 614–622	413–432 1047–1066
Cardale, H. J.	443–461	693–722
Cave, J.	210–213	293–305
Chambers, T.	431–434	661–668
Clements, P. A.	585–586	991–1000

Witness.	Statement of Evidence. Pages in Appendix to Minutes of Evidence.	Oral Evidence. Pages in Minutes of Evidence.
Cohen, J.	566–576	951–959
Collins, E. T.	524–527	861–869
Colyer, Sir F.	264–268	447–455
Comber, C. T.	480–482	755–766
Condry, A. H.	271–275	465–478
Conway, W.	492–493	798–806
Corbey, E.	614–622	1047–1066
Cox, A.	443–461	693–735
Cox, G. Lissant	622–624	1067–1070
Crew, T.	362–367	591–595
Dain, H. Guy	443–461	693–735
Daniels, F. W.	242–249	371–392
		409–413
Davis, C.	461–480	735–755
	547–548	898–905
Davis, S. G.	461–480	735–755
Deacon, H. W.	497–498	819–826
Dobson, Dr. Margaret B.	511–517	847–855
Donaldson, J.	593	1010–1019
Doubleday, Miss E.	565	944–951
Dudley, H.	177–200	140–188
Duff, S. L.	200–203	189–218
Duncan, J.	213–217	306–319
Dutton, T.	767	—
Eason, H. L.	527–531	869–875
Emmott, Lady	277–285	482–489
England, E. E.	249	392–400
Falconer, J.	300–302	544–552
Farmer, E. C.	285–289	489–499
Farris, W.	624–630	1070–1076
Fish, E. W.	264–268	447–455
Fisher, J. H.	524–527	861–869
Fletcher, Miss A. E.	547–548	898–905
Forrest, J.	500–511	836–847
Fox, F.	635–637	1084–1089
Francis, H. W. S.	674–683	1178–1194
Fraser, D. C.	292–295	511–519
Gaugain, Sir H.	622–624	1067–1070
Gilligan, Miss M.	565	944–951
Glyn-Jones, Sir W.	694–696	1204–1216
	763–764	—
Gold, J.	218–222	320–331
Goodacre, C.	362–367	591–595
Goodwin, F. A.	438–440	675–687
Gordon, A.	232–241	351 371
	277–285	482–489
Gordon, J. C. Lee	312–315	571–580
Grant, H. D.	547–548	898–905

Witness.	*Statement of Evidence. Pages in Appendix to Minutes of Evidence.*	*Oral Evidence. Pages in Minutes of Evidence.*
Greenyer, V. T.	480–482	755–766
Gregg, E. A.	461–480	735–755
Gregg, F. T.	500–511	836–847
Gregorson, J. A.	696–701	1216–1229
Grieve, J.	435–438	668–675
Hadow, Sir H.	498–499	826–830
Hall, G. Rome	750–752	—
Hall, J.	547–548	898–905
Hambleden, Viscount	497–498	819–826
Hamilton, A	491–492	791–798
Hamilton, Miss M. W.	440–442	687–693
Harford, C. F.	527–531	869–875
Harman, N. B.	443–461	723–724
Hatton, J.	635–637	1084–1089
Heather, E.	206–210	267–292
Henderson, J. C.	555–560	922–929
Henry, A.	595–598	1021–1024
Hibbert, E.	223–230	332–341
Hilbery, Miss M. A.	638–639	1089–1095
Hill, J. R.	548–553	905–915
Hill, Sir N.	302–311	552–568
	311–312	568–571
Hilton, J. E.	438–440	675–687
Hodgson, S.	443–461	724–726
Holdway, E. G.	250–251	392–400
Holmes, D.	491–492	791–798
Howkins, C. H.	271–275	465–478
Hubback, Mrs.	645–646	1104–1107
Huntley, T. W.	599–606	1028–1037
Huntrods, W.	541–542	888–894
Hutchinson, A.	541–542	888–894
Hyde, W.	297–300	527–544
Illingworth, J. P.	210–213	293–305
Jeffrey, J.	115–157	87–121
Jones, F. L.	367–401	595–625
	413–414	
Jones, R. H.	743–745	—
Kershaw, F.	614–622	1047–1066
Kewley, W.	499–500	830–836
Kinnear, Sir W.	3–75	1–43
	158–170	
	664–674	1130–1194
	674–683	
Lamb, S. R.	498–499	826–830
Leach, R. A.	607–612	1037–1043
Legge, Sir T. M.	424–431	649–661
Leishman, Sir J.	115–157	87–121
	684–693	1195–1204

Witness.	Statement of Evidence. Pages in Appendix to Minutes of Evidence.	Oral Evidence. Pages in Minutes of Evidence.
Lesser, H.	419–421	631–646
	639–645	1096–1104
Lewis, H. E.	414–417	625–629
Lewis, J. P.	177–200	140–188
		349–351
Lloyd, F. G.	—	—
Lyster, R. A.	493–497	807–818
Maclachlan, A. B.	674–683	1178–1194
Mallinson, G. A.	531–541	876–888
Marlow, W.	290–292	499–511
Marshall, W. M.	367–412	595–625
Maude, E. J.	76–101	61–62
	170–172	
May, O.	585–586	991–1000
Mayou, M. S.	524–527	861–869
McHoul, J.	518–524	855–861
McLean, W.	630–635	1076–1084
Melhuish, A. R.	531–541	876–888
Meller, R. J.	268–271	455–465
Mellersh, W. F.	547–548	898–905
Mennell, J. B.	543–547	894–898
Meynell, J. L.	518–524	855–861
Middleton, W. A.	649–662	1120–1124
Miller, E.	579–581	961–969
Moore, A. R.	767	—
Moss, J.	251–252	400–409
Neill, Sir T.	204–206	218–267
	285–289	489–499
Palmer, E. T.	204–206	218–267
Perry, Sir C.	543–547	894–898
Peterkin, Miss	560–563	930–940
Phillips, Dr. Marion	646–648	1107–1120
Pike, J. S.	285–289	489–499
Pooley, G. H.	527–531	869–875
Porter, F.	482–484	766–770
Potts, E.	367–401	595–625
Price, J. F. G.	662–664	1125–1130
Pride, S.	489–490	784–791
Pring, C. H.	767	—
Pugh, E.	492–493	798–806
Reid, J.	582–583	975–982
Reynard, M. A.	583–584	982–987
Rhodes, M. R.	753–754	—
Richardson, E. Y.	259–264	432–447
Richmond, Mrs. B.	560–563	930–940
Roberts, Harry	484–486	770–778
Roberts, Hugh	742–743	—
Roberts, J. H.	491–492	791–798
Roberts, J. M.	635–637	1084–1089

Witness.	Statement of Evidence. Pages in Appendix to Minutes of Evidence.	Oral Evidence. Pages in Minutes of Evidence.
Rockliff, P.	242–249	371–392
		409–413
	252–259	413–432
Russell, W.	482–484	766–770
Saunders, A. J. E.	290–292	499–511
	435–438	668–675
Shaw, D.	223–230	332–341
Shaw, J. W.	290–292	499–511
Shaw, L.	231–232	341–349
Smith, R.	438–440	675–687
Spurgeon, E. F.	204–206	218–267
	268–271	455–465
Stevens, F. B.	754–757	—
Strohmenger, E. J.	101–114	121–140
	173–174	
Sutcliffe, J. H.	511–517	847–855
Syddall, S. A.	489–490	784–791
Syder, E. W.	292–295	511–519
Thomson, W.	581–582	969–975
Torrance, W. J.	200–203	189–218
Turner, E. B.	585–586	991–1000
Varrier-Jones, P. C....	587–588	1000–1004
Viney, Miss H.	563–564	940–944
Wager, A.	594–595	1019–1021
Wale, H. W.	312–315	571–580
Wall, R. B. C.	594–595	1019–1021
Walmisley, G. H.	589–593	1004–1010
Ward, G.	461–480	735–755
Waring, C. H.	251–252	400–409
Watson, J. B. Forbes	696–701	1216–1229
Watt, Miss J. P.	563–564	940–944
Webb-Johnson, A. E.	499–500	830–836
Welply, A.	461–480	735–755
West, F. T.	316–362	580–591
Whitaker, J. Smith	76–101	44–87
	170–172	
	664–674	1160–1194
	674–683	
Wigoder, P. I.	271–275	465–478
Williams-Freeman, J. P.	443–461	734–735
Williamson, R.	584–585	987–990
Wight, G. W.	115–157	87–121
	684–693	1195–1204
Wing, J. C.	271–275	465–478
Wood, B. J.	259–264	432–447
Wood, W.	297–300	527–544
	300–302	544–552
Woodhead, D.	593	1010–1019
Wright, G.	316–362	580–591
Yoward, W. D.	367–401	595–625

II.—BODIES.

(*Note.*—A particular body may appear more than once in this list under different verbal arrangements of its title.)

Body.	*Statement of Evidence. Pages in Appendix to Minutes of Evidence.*	*Oral Evidence. Pages in Minutes of Evidence.*
Aberdeen Association of Approved Society Officials	745	—
Ancient Order of Foresters' Friendly Society	200–203	189–218
Apothecaries, Society of	594–595	1019–1021
Association of Approved Societies ...	438–440	675–687
Association of Certificated Dispensers ...	594–595	1019–1021
Association of Infant Welfare and Maternity Centres	758–759	—
Association of Insurance Committees, Scottish	402–412	595–625
Association of Jewish Friendly Societies	767	—
Association of Parish Councils of Scotland	583–584	982–987
Association of Poor Law Unions in England and Wales	607–612	1037–1043
Association of Trade Union Approved Societies	614–622	1047–1066
Association of Welsh Insurance Committees	413–414	595–625
Audit Department, National Insurance ...	649–662	1120–1124
Baltic and Corn Exchange Health Society	249	392–400
Beneficent Society, National Insurance...	252–259	413–432
Board of Education	729–730	—
Bristol, West of England and South Wales Operatives' Trade and Provident Society	739–740	—
British Dental Association	259–264	432–447
British Hospitals Association	497–498	819–826
British Medical Association	443–461	693–735
British Ophthalmologists, Council of ...	524–527	861–869
British Optical Association	518–524	855–861
British Social Hygiene Council	585–586	991–1000
British Society of Dental Surgeons ...	264–268	447–455
Cambridgeshire Tuberculosis After-Care Association	587–588	1000–1004
Catholic Approved Societies, Group of ...	251–252	400–409
Chartered Accountants of Scotland ...	582–583	975–982
Chartered Society of Massage and Medical Gymnastics	543–547	894–898
Cheshire Insurance Committee	316–362	580–591
College of Nursing	563–564	940–944
Committee of English, Scottish and Welsh Associations of Insurance Committees, Federation	367–401	595–625
Confederation of Employers' Organisations, National	696–701	1216–1229
Conference of Friendly Societies, National	290–292	499–511

Body.	*Statement of Evidence. Pages in Appendix to Minutes of Evidence.*	*Oral Evidence. Pages in Minutes of Evidence.*
Council of Agriculture for England, National	593	1010–1019
Council of British Ophthalmologists ...	524–527	861–869
Council of Panel Chemists (Scotland), General	548–553	905–915
Coventry Insurance Committee	312–315	571–580
Dental Association, British	259–264	432–447
Dental Service Association of Great Britain, Limited, Public	271–275	465–478
Dental Society, Incorporated	295–297	519–527
Dental Surgeons, British Society of ...	264–268	447–455
Dentists' Panel, East of Scotland	579–581	961–969
Dispensers, Association of Certificated	594–595	1019–1021
Distribution Committee (Central Medical Pool)	730–736	—
Durham Miners' Association Approved Society	740–741	—
East of Scotland Dentists' Panel ...	579–581	961–969
Edinburgh, Leith and District Friendly Societies' Council	584–585	987–990
Edmonton Union	767	—
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